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ABSTRACT

The monograph presents state-of-the-art assessments of available research pertaining to the American Indian/Alaska Native, Pacific Asian, Hispanic, and Black elderly. These assessments, prepared by five prominent minority gerontologists (John Red Horse, Sharon Y. Moriwaki, Sylvia Yuen Schwitters, Jean Keith Crawford, and Maurice Jackson), reflect what is known and not known about aging and older persons in each minority group; identify contradictions, trends, and gaps in data; address the most important aging human service issues; discuss possible implications of a proposed Human Service Model for older persons in each minority group; and provide recommendations for future research and human services policy. General observations are given on the history, trends, and gaps in minority aging research. To provide perspective, the introduction and summary of the report "Future Directions for Aging Policy: A Human Service Model" (1980), by the Subcommittee on Human Services, Select Committee on Aging is provided. These reveal some of the basic assumptions that guide the Human Service Model. A cross-cultural summary with broader minority aging conclusions highlights the important shared perspectives and variations on themes. The monograph concludes with six state-of-the-art bibliographies which constitute a comprehensive collection of 1,600 references by subject area and ethnic focus. Although many of the materials can be located at major libraries, the majority are located in the archive collection at the University Center on Aging, San Diego State University. (NQA)

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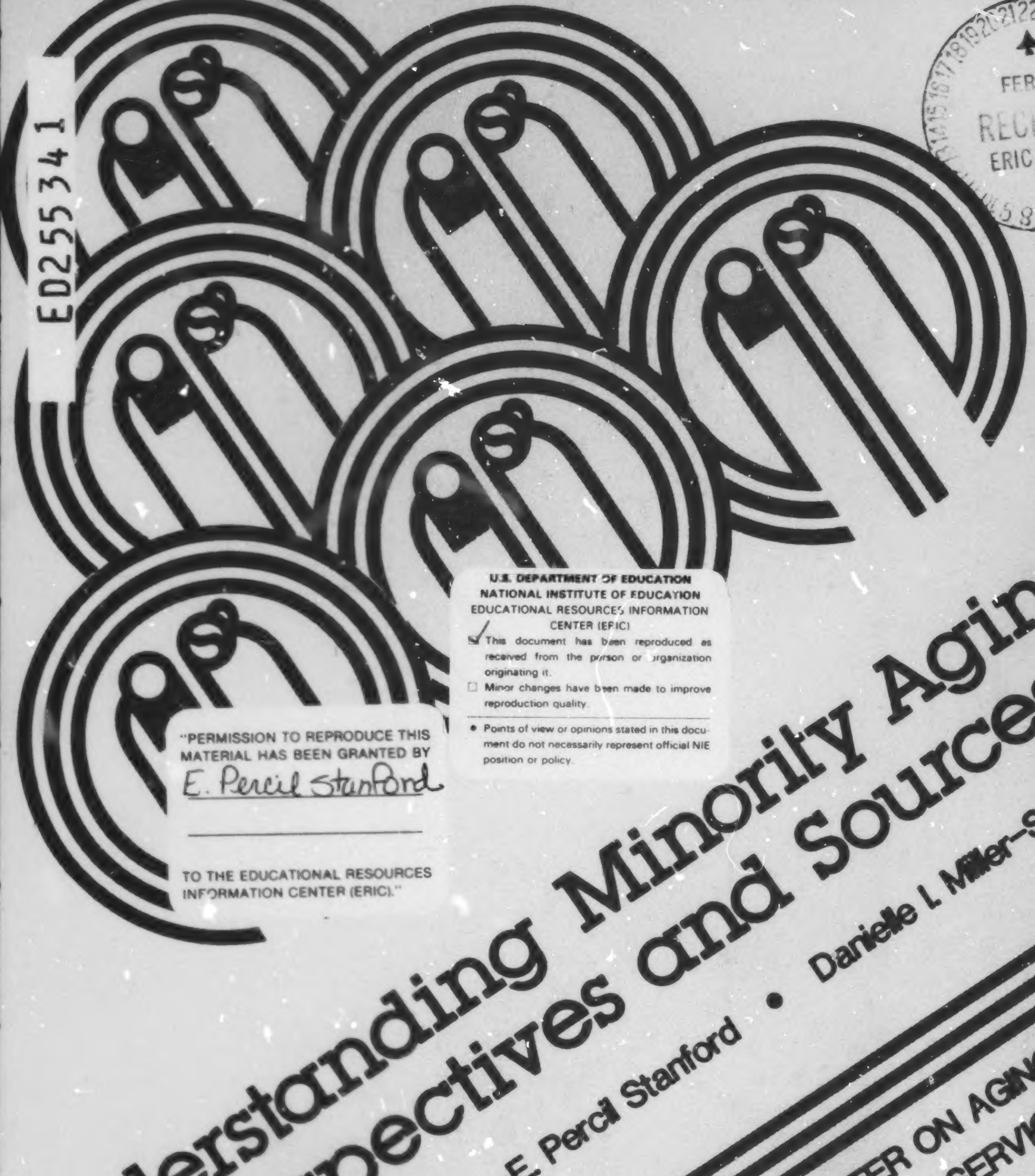

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Understanding Minority Aging: Perspectives and Sources

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UNIVERSITY CENTER ON AGING
COLLEGE OF HUMAN SERVICES
SAN DIEGO STATE UNIVERSITY

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UNDERSTANDING MINORITY AGING: PERSPECTIVES AND SOURCES

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FORWARD

This monograph has been developed in response to a need in gerontology with respect to minority aging. Researchers, providers, administrators, planners, teachers, students, advocates, and others in the aging network, have long decried the lack of ready references to serve as guides and verification sources for those working with ethnic minority or culturally different elders. Recognizing this need, the Administration on Aging provided funds in 1980 for the development of processes and materials that would help to delineate the scope and nature of available materials in minority aging research, and identify the more salient gaps and trends.

The project's timing is crucial. We are now entering a period, the 1980s, characterized by a general re-examination of the state of gerontology, and an unfortunate general reduction in resources available to support aging research activities, particularly with respect to conditions and needs of minority elders. Furthermore, and even more important, there has recently been a general shift in the ideological underpinning of the system of human services for older persons in the United States. This shift involves moves away from federal to local decision-making and resource allocation, away from general services to all elders to targeted aging services for only frail and functionally dependent elders, and away from artificial bureaucratic networks to natural community networks. Although potentially beneficial to minority elders, unfortunately this shift reflects a great deal of ignorance of issues impacting the lives of minority elders in different ethnic groups. The coming decade will witness the making or breaking of research needed to begin to develop aging policies and regulations that ensure all older people are served primarily on the basis of need, rather than for other reasons. The ethnic-specific critiques of the proposed aging policy directions prepared on the basis of available materials by analysts selected by four minority aging organizations, which have been included here, are important steps in the right direction. They highlight some of the important negative considerations, as well as potential implications, of the shift in emphasis.

During coming years "professionals" in gerontology are going to have to respond even more cogently and convincingly to the increasingly probing questions of older persons, including minorities, who demand to know why their best interests and worst needs are ignored by those whose daily actions affect their life course, and sometimes their life span.. It is, therefore, imperative that there be as many references as possible available to those concerned with accurately addressing the questions and needs of older minority persons.

The Minority Aging Codification Project was undertaken to provide an update of the available literature that can be used as references for the advancement of future research, training, and other endeavors in the area of minority gerontology. The general notion that there is little printed material available on minority aging has persisted for over a decade. This project identified more than twice the number of references expected. This area has grown at a phenomenal rate. Still, there are many deficiencies.

A primary intent of this project has been to critically assess the limitations of the available research literature. This means more than merely determinig the extent of information and knowledge available on minority aging for the purposes of future research, training, and demonstration projects. This means pointing to subjects and populations that have received the least attention, and those close to the satiation point of limited returns.

Since this is the first time a project has been undertaken on such a large scale, it has resulted in some interesting and important findings. For the first time there is an indication of the chronological development of minority aging research, the contributions made by different individuals to the development of minority aging knowledge, and the sources where the materials can be found. After reviewing the processes followed to uncover much of the information identified by the project, it should be obvious that the minority aging research materials are as disparate in substance as they are in source.

An assumption often made in gerontology, as also the case with other disciplines or fields, is that most of the written research findings and discussions would be classified as "minority" or according to some other appropriate "ethnic identifying tag." This project has revealed that much of the relevant minority aging research literature does follow this general pattern, and can be categorized according to major ethnic groups, Black, Hispanic, Pacific/Asian, and American Indian/Alaskan Native.

The surprise was that many of the materials have not been specifically identified within one ethnic group or another, but rather have been placed under the general rubric of "minority." Moreover, some of the materials are camouflaged (without reference to either minority or ethnicity status, and sometimes without references to aging content) and buried in other than gerontology or ethnic studies literature. A conscious effort has been made to identify relevant materials, whereever they were found. One of the important contributions of this project has been the inclusion of these materials to the extent possible. The bibliographies developed represent the state-of-the-art in minority aging research.

It might have been unwise, but easy, to continue for another decade or so without assessing the status of minority aging research. The undesirable consequences might have been continued fragmentation and duplication of efforts, as well as overattention to some subjects and populations at the expense of underdevelopment of others. Instead, now there is an opportunity to build on the information provided by this project and determine the nature of still-needed research as well as the direction of future service delivery programs concerned with minority elderly, most of whom remain among the most needy, in every sense of the concept, older persons in the nation. This will require cooperation and collaboration of the most committed kind among all concerned.

It should be noted that this project is also unique because it was carried out in collaboration with the Asociacion Nacional Pro Personas Mayores, the National Caucus and Center for Black Aged, the National Indian Council on Aging, and the Pacific/Asian Resource Center on Aging.

Without their involvement and support, the advances made might have been more modest and less significant. In some respects, this collaboration represents a methodological benchmark and prototype for future cross-ethnic efforts.

INTRODUCTION: THE MINORITY AGING CODIFICATION PROJECT

Background

By the year 2000 the number of older minority persons in the United States will almost double. It is anticipated that the total number of minority individuals over the age of 65 will be over five million. This represents an increase of 2.2 million over the 1978 figures and an increase of over 3.8 million over the 1960 census figures.

This dramatic change in our demographic structure has stimulated a growing awareness of the need for better understanding of the conditions and circumstances of older minority persons of different ethnic heritages. This project represents an effort to develop a systematic knowledge base about older minorities upon which future planning efforts in both research and human services delivery can be based.

It is generally known that older minorities received much less research attention than any other population segment during the formative years of gerontology. The reason minority aging was ignored by the first generation of gerontologists is that they were involved in delineating the parameters and specific issues of the emergent discipline which focused attention on the "elderly" per se, with the broad-based assumption that "the aged" were "a relatively homogeneous group manifesting a series of common needs."

The concept of "minority" was not introduced into gerontology jargon until 1953, when Barron explored its applicability to the aged in American society. Barron's provocative effort reflected the conditions of older Americans against the dimensions of Louis Wirth's theoretical definition of a minority as a group of people who, because of their physical or cultural characteristics are singled out from others in the society in which they live for different and unequal treatment, and who therefore regard themselves as objects of collective discrimination. Since Barron's seminal discussion of the aged as a minority in society, the thought that older persons are objects of collective discrimination and subjected to different and unequal treatment because of their physical and cultural characteristics remains hypothetically plausible, and open to empirical evidence.

It was not until the late 1960s that the attention of gerontologists was drawn toward the elderly in minority communities. The first studies were primarily descriptive evaluations of problems, patterns of adjustment and utilization of services, or "state-of-the-art" discussions of existing gaps in knowledge and understanding of how segments of older minority perons differ from the majority or one another.

The roots of minority aging research as a distinct area of specialization within social gerontology were planted in 1971 with the pioneering publication of the seminal essays by the precursors of minority gerontology -- Jacqueline Jackson, Joan Moore, Donald Kent, Richard Kalish, Margaret Clark, among others. The perspective articulated by Joan Moore in her work "Situational Factors Affecting Minority Aging," has come to be recognized as a cornerstone of minority gerontology. It clearly identifies four characteristics which mark the minority experience as unique: (1) minority groups have their own special histories; (2) minority group histories are typically accompanied by negative stereotyping; (3) minority groups are characterized by the institutionalization of positive coping structures; and finally, (4) minorities are faced with a need to take these factors into consideration in any attempt to understand the nature of aging and the circumstances of the aged in United States minority communities.

In recent years, the research literature on minority aging has grown at an exponential rate. Yet, researchers and service providers alike continue to lament the paucity of information available on minority older persons. One of the major problems in minority aging is that the available information is not conveniently accessible to students, researchers, service providers and policy makers who need it. This lack of accessible current information results in the transmission of inadequate knowledge, impedes the development of viable public policies and programmatic models, and impairs opportunities for scientific research investigation in minority gerontology. Without accurate data, planners and service providers are also limited in their ability to provide adequate and timely services to older minorities in their communities.

Two recent landmark documents addressed the need for some synthesis of minority aging research literature. In 1976, Bell, Kasschau, and Zellman published, "Delivering Services to Elderly Members of Minority Groups: A Review of Literature." That work represents the first attempt to inclusively summarize existing literature on human services to minority elderly. To this date, the document is widely utilized and cited as a valuable state-of-the-art resource. Nonetheless, a recognized limitation of the work is the lack of information on many important ethnic variations within the broad minority categories.

A 1978 Human Resources Corporation report titled, "Policy Issues Concerning the Minority Elderly," represents the first conscientious effort to assess the impact of contemporary policies and major programs on the lives of minority older persons. Working with a more limited research base than Bell, Kasschau and Zellman, the work focused on the retrieval of information from systematic research on the extent to which policies and programs are fitted to meet the needs of minority elderly.

Purpose and Goals

This project builds upon the strength of the past landmark efforts and addresses some of their more salient limitations. The purpose of this project is to codify research on older minority persons in order to identify methods for improving the quantity, quality, utilization and effectiveness of both formal and informal human services. The term "codify" means "to arrange in a systematic way."

Several specific project goals were established under this broad purpose. These can be best described by considering the four distinct project activity phases. These were: (1) collection and codification of minority aging research materials; (2) analysis of materials and data; (3) formulation of recommendations for future research and human services delivery; and (4) dissemination of project findings and products. Although distinct spheres of activity, these areas are interdependent upon the successful completion of preceding goals.

Within the first phase of activity, the goal was to establish an organized body of minority aging knowledge. The body of information will be structured around the four major ethnic group classifications

(American Indian/Alaskan Native, Black, Hispanic, and Pacific/Asian) and twelve subject categories (Health, Nutrition, Social Network/Family Relations, Public Policy/Legislation/Legal, Housing/Living Arrangements, Employment/Retirement, Income/Economics, Transportation/Mobility, Mental Health, Education, Leisure/Recreation, Literature Review/Overview). The systematic organization of knowledge clearly identifies what is available as well as what is not available within each of the twelve areas of interest. The products of this effort are the codified lists of references presented as ethnic-specific and multi-ethnic bibliographies, and the uncodified list of references or bibliography. Combined, these represent the most comprehensive listing of minority aging references ever produced.

A second goal of the project was to identify trends and gaps in the knowledge, as well as to determine the reliability of the research data upon which that knowledge was based. The third goal was to develop recommendations for future research and human services delivery. The ethnic-specific assessments of the 1980 Select Committee on Aging's proposed Human Service Model, and the brief review of the historical development of minority gerontology combine to meet these goals.

The fourth goal is perhaps the most important one: that the information and materials collected and codified, products generated, and recommendations advanced, are widely disseminated to facilitate utilization. During the span of the project, a concerted effort was made to identify, scan, acquire, index, organize and file minority aging research documents available. Approximately 1,500 references minority aging have been identified. The project was able to acquire more than 750 reports, essays, dissertations, theses, unpublished papers and manuscripts, as well as 43 bibliographies. The project newsletter, the Minority Aging Exchange (MAE), served as one means of disseminating project findings, soliciting copies of hard-to-find documents, and publishing lists of materials and products which have been available. In all, the MAE newsletter functioned as the primary means of communication and information exchange within the minority aging research network.

An expected long-range outcome of this codification activity will be the development of a deliberate and well-directed plan for knowledge building in minority gerontology. The MAE newsletter established an open means of communication and information exchange which involved a wide variety of professions and perspectives, and more than 1,000 individuals with an expressed interest in minority aging. The completed project has maintained and expanded past networking efforts. One of the more important functions of the project has been to identify little-known resources on minority aging, and generate policy recommendations and practical solutions to meet the needs of older minority persons and improve their life circumstances somewhat. Over time, this effort should contribute to the development and implementation of comprehensive coordinated service systems designed primarily for the most needy and functionally dependent older persons regardless of race, culture, gender, or age.

Structure and Methodology

The project was structured in three dimensions. The University Center on Aging, San Diego State University, was at the hub of the structure, coordinating the overall codification effort. The project staff and materials were housed at the University Center on Aging..

The national minority aging advocacy organizations constituted a second dimension of project structure. These were the National Caucus and Center on Black Aging, Inc., Asociacion Nacional Pro Personas Mayores, the National Indian Council on Aging, and the National Pacific/Asian Resource Center on Aging. Their participation was formalized during the initial phase of the project. Functioning in a support capacity, these organizations provided valuable project input at critical points in its development. Most important, these organizations contributed copies of hard-to-obtain materials from their own libraries to the codification collection. Representatives from these organizations provided critical feedback on the state-of-the-art assessments and recommendations for future efforts relating to minority aging research and the improvement of human services for minority older persons.

The Administration on Aging formed the third dimension of the project's structure. As information on minority aging was systematically collected, it was organized and standardized in a manner that facilitated integration of findings into the national aging information retrieval system supported by the Administration on Aging, SCAN. SCAN staff provided input and feedback on the development of the Minority Aging Codification collection And, periodically, SCAN was provided lists and hard copies of important minority aging references.

The project was divided into four working phases. During the first phase, activity focused on orienting and training project staff, and finalizing the conceptual framework for the total codification effort. A meeting was conducted with representatives from the minority aging advocacy organizations. The purpose of this first collaboration meeting was to review, refine, and finalize the project's conceptual framework; clearly define the parameters of the working relationships between the minority organizations, the University Center on Aging; establish project deadlines; and establish guidelines for the collection and analysis of materials.

During the second phase, project staff, working closely with representatives of the four minority aging advocacy organizations, established criteria for the selection of documents and materials included in the codification collection: each had to have a significant focus on aging or later life and on members of minority groups that have been subjected to collective discrimination, unequal treatment because of their racial or cultural characteristics--including, American Indians, Alaskan Natives, Black Americans, Mexican Americans, Puerto Ricans, Cuban Americans, Central Americans, Hispanic or Latino Americans, Pacific Islanders, Hawaiians, Samoans, Guamanians, Pilipino Americans, Korean Americans, Japanese Americans, Chinese Americans, and IndoChinese Americans.

The materials and documents collected by the Minority Aging Research Development (MARD) Project at the SDSU Center on Aging during the previous year formed the core of the codification collection. Additional documents and minority aging materials generated by this project were systematically acquired, integrated, stored and prepared for use by other researchers. Early during this phase of the project, staff met with SCAN personnel to discuss methods of minority aging information preparation for incorporation into the SCAN system.

Some activity during the second phase also focused on the exchange of information with other systems, including the Smithsonian Science Information Exchange (SSIE), Educational Resources Information Center (ERIC), and Medical Literature Analysis and Retrieval System On-Line (MEDLINE). This effort was less than successful, since most of these systems included few minority aging references or documents.

A major task during this phase was to identify all documents, including hard-to-get papers, dissertations, educational and training materials, legislative and regulatory materials and program descriptions that dealt with minority aspects of aging, and then to create lists of the identified documents and materials. The staff scanned relevant journals and periodicals, giving highest priority to current literature and providing complete coverage of the major journals.

The logical next task was to acquire all publications identified as potential entries. An active attempt was conducted to acquire "fugitive" literature, such as papers presented at meetings, substantive reports of state or area agencies, grant and contract reports, and other documents and manuscripts not widely disseminated.

Once selected, the documents were prepared for entry into the codification system. All documents and materials were recorded immediately at the point of entry and tracked through the entire processing until the document was permanently filed. Each document was assigned a unique identifier. Checks assured against duplication or omission of documents in the system. Each document was indexed according to ethnic minority focus and primary subject matter.

A card catalog system was developed and maintained. This card catalog system included cross references by the ethnic minority group, by subject matter, and by key descriptors.

Toward the conclusion of the acquisition and codification phase, project staff focused on the in-depth analysis of the materials collected and indexed. The information and data collected on each of the major groupings of older minority persons were analyzed at three levels. At the first level of analysis, gaps and trends will be identified. Gaps include absence of information, outdated or irrelevant data. Trends are characterized by dominant themes. Some effort was made to assess the reliability, validity, and generalizability of available research on minority aging.

The second level of analysis determined the existence or absence of current information and data on human services delivery to older persons in the various minority groups. Specifically, the project has identified relevant research which addresses issues of availability, suitability, accessibility, and effectiveness of human services for minority older persons.

The third level of analysis of a state-of-the-art assessment of available research for each of the broad minority groups as reflected against a major policy statement intended to guide the future direction of aging programs. These assessments, prepared by five prominent minority gerontologists, review research findings, identify contradictions, trends and gaps in data, and make recommendations for future research and human services policy.

A three day mini-conference was held to present project findings and make specific recommendations for furture directions of minority aging research and human services delivery. Representatives of the four collaborating minority aging advocacy organizations, along with other specialists in minority aging were invited to participate and provide critical feedback on the research and policy recommendations being advanced. These preliminary assessments of the current status and future directions of minority aging were edited and published as part of the proceedings of the Eighth National Institute on Minority Aging (Stanford and Lockery, 1982).

During the span of the codification project, staff responded to requests for information within ten working days by: (1) searching the data base, and referring users to appropriate documents; (2) conducting a SCAN search; and (3) searching for unpublished information, describing the relevant materials to users, and providing accessing information such as how to use card catalog and codified bibliographies, office hours, identifier numbers; and/or (4) referring users to SCAN, and/or minority aging advocacy organizations if they appeared capable of further assisting the user. A full record control was maintained for each request.

The special bibliographies prepared by the project consist of references plus codifiers for each of the four broad minority categories, and a multi-ethnic (cross-cultural or comparative) listing. The preparation included detailed searches of all relevant data bases, information and retrieval systems, periodicals, and bibliographies. A listing of minority aging references identified, but not entered in the codification system, was also created and called the "Uncodified Bibliography." The methodological details of bibliographic development are spelled out in the chapter titled, "The Minority Aging Bibliographies."

MINORITY AGING RESEARCH: HISTORY, TRENDS, AND GAPS

The twofold purpose of this section is to present a summary overview of the development of minority gerontology--from its start as the practice of a few insightful precursors to its present state as a subfield of gerontology that is an area of specialization for an increasing number of researchers and teachers, service providers and advocates--and to present an analysis of the state-of-the-art, in the broadest possible terms. The main point is that over the last ten years, minority aging scholar-activists have made significant gains toward (1) the establishment and expansion of a distinctive body of empirical and critical knowledge, (2) the development of characteristically transdisciplinary methods and perspectives, and (3) the creation of formal and informal networks of minority researchers, teachers, planners and service providers in structured relationships and organizations which are based on their shared interests, activities and concerns. In sum, this arena called "minority aging" or "minority gerontology" has evolved with certain characteristics and specific dimensions, a number of which distinguish it from the wider field of gerontology in marked ways.

The critical analysis of trends and gaps in minority aging research presented in this section examines the extent to which different minority older persons and various subjects have been addressed by the research. State-of-the-art limitations are noted. An important finding is that certain minority groups and some subjects have been virtually ignored. Recommendations for improvement are made.

Trends, 1950-1980

Much of the activities in the arena of minority aging have centered around those tasks characteristic of an academic subfield of research and development in its embryonic and natal phases. It may well be, as recently suggested by Markides (1980), one of the most underdeveloped arenas in social gerontology, but with good reason.[1] As noted in the Introduction, it is a well-accepted fact that minority aging was virtually ignored by dominant gerontologists during the field's early phases of development. The fact that more minority aging researchers have only recently looked beyond comparative analyses of sociodemographic factors (e.g., income, sex, retirement statuses, marital statuses, and the like) to examine critical questions of the extent to which ethnic minority status, politico-economic class, and sex status differentially and collectively affect circumstances, conditions, and most important, level of needs in later life for various segments of minority older persons, marks a level of scientific achievement, rather than failure. Indeed, it has been slightly more than a decade since there was any significant expansion of research on minority older persons. Although our efforts concentrated on research since 1970, our wide-ranging search has revealed fewer than 100 references to minority aging prior to 1971.

Among the earliest references, if not the earliest direct reference, to minority aging in gerontological literature is J.L. Wilson's "Geriatric Experiences with the Negro Aged." Published in 1953, the same year that Milton Barron published his examination of the aged as a minority in United States society, Wilson's work has received much less gerontological consideration than has Barron's.

In 1955, two of the first minority aging theses were filed: E.G. Sherman's, "Social Adjustment of Aged Negroes of Carbondale, Illinois," at Southern Illinois University, and W.Y. Kanagawa's, "A Study of Old Age Assistance Recipients of Japanese Ancestry Under Honolulu County Department of Welfare," at the University of Hawaii. Four years passed before another minority aging thesis was filed: M.L. Hamlett's exploratory study of the socio-economic and psychological problems of adjustment of 100 aged and retired Negro women in Durham, North Carolina during 1959.

Probably the first minority aging demographic study was published in Phylon, T.L. Smith's (1957) "The Changing Number and Distribution of the Aged Negro Population of the United States." The first minority aging comparative study, published in the 1958 Journal of Gerontology, was "Relation of Serum Cholestrol to Age, Race, and Sex in a Community Group of Elderly People" by C.R. Nichols and W.D. Obrist. Also published in 1958 was T.E. Bessent's "An Aging Issei Anticipates Rejection."

Together these represent the thrust, if not the sum total, of the minority aging research carried out during the 1950s. However modest, this beginning exhibits certain trends. First, it has a problem-oriented rather than basic research orientation. It is interesting that the first minority aging studies of other than Negro older persons were conducted among the aging Japanese Americans. It is also important to note that as early as 1958 some researchers were already addressing cross-group comparative questions, as well as questions of the effects of culture conflict and change on the lives of older ethnic minorities.

Minority aging studies during the 1960s continued to address questions concerning recipients of old age assistance (Henderson, 1961; Orshansky, 1964; Henderson, 1965), the effects of acculturation (Boyer, et. al., 1964-65; Chen and Chen, 1964), the effects of racial and ethnic differences on the characteristics and attitudes of older persons (Roberts, 1964; Heyman and Jeffers, 1964; Harper 1967; Nash, Lawton and Simon, 1968; Hirsch, Kent and Loux, 1968; Weinstock and Bennett, 1968; Kent and Hirsch, 1969) assessments of later life adjusment (Himes and Hamlett, 1962; Eisdorfer, 1963) demographic issues (Demeny and Gingrich, 1967; Goldstein, 1963; Thornton and Nam, 1968), and various problems of minority older persons, such as housing (The Arlington Community Action Committee, 1966; Nash, Lawton and Simon, 1968; Carp, 1969; Penasi and Marques, 1969), economic dependence (Solomon, 1966) or low income (Dhaliwal, 1966) or unemployment (Aiken and Ferman, 1966), relocation (Reich, Stegman and Stegman, 1966), widowhood (Lopata, 1968), health (Weeks and Darsky, 1968), and communication (Weinstock and Bennett, 1968). But a number of new issues concerning minority aging and older persons were also raised during the 1960s. These included questions of the effects of discrimination (Henderson, 1965), kinship (Lopata, 1968; Jackson, 1969) and friendship (Rosenberg, 1968) factors, racial attitudes (Thune, 1967), retirement (Jackson, 1969; Moore, 1969), and leisure-time (Jackson, 1967).

The concept of "double jeopardy" was first introduced in a 1964 National Urban League publication. A similar notion was advanced in T.F. Pe Higrew's 1967 unpublished manuscript, "The Negro Aged: A Minority Within a Minority." The basic point was also underscored in 1967 by the National Council on Aging's "Plight of Elderly Among Minorities."

The first studies of factors in the utilization of services by minority elderly were published in the late 1960s (Carp, 1968; Nadler and Schreiber, 1968). H.C. Jackson first discussed,"Overcoming Racial Barriers in Senior Centers," in 1965. The first reports on the availability and usefulness of federal programs and services to elderly Mexican Americans in different areas were published in 1968-1969. And I. Dieppa's 1968 paper, "Reaching the Elderly Poor Through Project FIND: Implications for Practice in Voluntary and Public Agencies," appears among the first to discuss strategies for increasing access to services by older minority persons. Also published during 1969 were the proceedings of a conference on improving services to aging Mexican Americans in East Los Angeles.

The first studies of minority aging that focused on urban-rural issues were also produced during the later part of the decade. Although the more sophisticated effort centered on Georgia Negroes (Ball and Jackson, 1966; Jackson and Davis, 1966; Jackson and Ball, 1966; and Jackson, 1967), the essays by Smith on,"The Older Rural Spanish-Speaking People of the Southwest," in E.G. Youmans, 1967 Older Rural Americans, represent the first attempt to present a summary overview of different ethnic minority older persons in the same context.

The late 1960s also marked the publication of J.J. Jackson's critical assessments of the Negro aged and social gerontology; the first in the Gerontologist (1967) and the second in the Journal of Social and Behavioral Sciences (1968). These seminal essays help establish critical intellectual tradition in minority aging studies; one that centers on the rigorous analysis and critique of dominant perspectives and institutions affecting the processes of minority aging and the conditions of minority older persons. This critical perspective has now become one of the primary dimensions of minority gerontology.

The scope of minority aging research expanded during the 1960s to include older persons in other than Negro or Japanese American minority communities. Indeed, the first survey of needs and resources among aged Mexican Americans was reported in 1968 by Steglich, Cartwright and Crouch.

By 1970, it was evident that increased attention was being given to issues of aging among minorities. The effort remained focused on problems having to do with communication (Carp, 1970), longevity (Hill, 1970), demographics (Hill, 1970), mental health (Elam, 1970), and coping reactions (Stretch, 1970). It was also evident that more attention would be given to questions of changing status of elders in different ethnic communities (Maxwell, 1970; Edgerton, Karno, and Fernandez, 1970).

The year 1971 marked the emergence of minority aging as a distinct subfield of gerontology. Most important was the set of seminal essays by J.J. Jackson, J.W. Moore, D.P. Kent, Kiefer, Kalish and Yuen, published together in the *Gerontologist*. These identified needed areas of research, but even more, helped define some of the more basic dimensions of the arena called minority aging. These dimensions were underscored by the series of essays published as *Minority Aged in America: Occasional Papers in Gerontology* by University of Michigan's Institute of Gerontology, and a collection of papers also published together in 1971 by *Aging and and Human Development*.

The often-cited works of J.J. Jackson and Kent confirmed the *critical* dimension of minority aging studies. J.W. Moore's "Situational Factors

Affecting Minority Aging", established the need for a holistic perspective that includes a multimethodological approach and a multilevel analysis. Moore's work strongly advocates for the introduction of a historical framework be used during the analysis of data. R.A. Kalish's "A Gerontological Look at Ethnicity, Human Capacities, and Individual Adjustment" established the groundwork for what has later been called a reflexive dimension, meaning the analytical introspection in the research process that involves a critical review of basic assumptions surrounding the research issue and population, as well as any biases or prejudices that may affect data collection and analysis (Cuellar, 1979). An important concern is to expose clearly the ethnocentric and chauvinistic biases that reflect the values and virtues of the researchers' community, ignore its faults, and depreciate those values and virtues of other communities. It is this reflexive dimension that fundamentally links minority gerontology to the Insider orientation.

The report by Kent, Hirsch and Barg (1971) "Indigenous Workers as a Crucial Link in the Total Support System for Low-Income, Minority Group Aged: A Report of an Innovative Field Technique in Survey Reearch," provided early support for adoption of the Insider's principle by minority gerontologists. An "Insider" is defined as a member of a specified collectivity who occupies a position in its structure; that is, someone who shares responsibilities and liabilities, privileges and duties in relationship to other members (Cuellar, 1979). The Insider orientation holds that the Insider, by virtue of social location, has access to certain sociocultural information not as readily accessible to Outsiders (those in other social locations). The premise for this holds that one of the privileges of social rank (in every sense of the concept) is access to restricted information. The methodological implication is that minority researchers as Insiders have structurally imposed potential to develop their familiarity with privileged information into theoretical knowledge about their communities. This means that socialized in and over time, the Insider with research training has the developed capacity to turn an acquaintance with problems and needs, historical events and contemporary conditions, into a critical understanding of some of their possible causes and solutions.

Other reports gave 1971 added significance for minority gerontology. One was H.C. Jackson's discussion of the establishment and progress of the first minority aging advocacy organization, the National Caucus on the Black Aged. Others were those produced by the White House Conference on Aging. It is also important to note that as early as 1971 there was a discussion of trends in long term care with reference to minority aging presented before the U.S. Congress, Senate Special Committee on Aging (H.C. Jackson, 1971), as well as a discussion of the multiple hazards of age and race (Lindsay, 1971). The year 1971 also witnessed the first reports on the work of Self-Help for the Elderly Program with the elderly of San Francisco's Chinatown (Yuen, 1971).

The proceedings of the first research conference on minority group aged in the south were published by Duke University Center for the Study on Aging in 1972. Some of the first proposals to eliminate barriers to legal services (Reynoso, 1972) and develop models for community support of minority group aged were also published that same year (Barg and Hirsch, 1972). Also in 1972, Afro-American Studies published its first state-of-the-art essay, A.H. Jenkins, "The Aged Black: Some Reflections on the Literature," which, in effect, established the fundamental relationship between minority aging and ethnic studies.

The first discussion of curriculum needs on aging minorities and education for minorities in aging appeared in 1972 (Stanford, Hawkinson, Monge and Dowd; Beattie and Morgan). These helped set the foundation for the later establishment of the three major shared goals of most contemporary minority gerontologists: (1) an increased number of minority professionals and paraprofessionals in the field of aging; (2) a well developed gerontology curriculum with minority components that accurately reflect the conditions, circumstances, needs, and histories of the various older minorities in the United States; and (3) well-established research, educational, sociocultural, and politico-economic action programs and service delivery systems to help solve the most pressing problems of older minorities. These goals are grounded in the manifested ideological premise shared by most minority gerontologists, researchers and practitioners: self determination for minority older persons and communities.

Although it has received little consideration by most in the field, it is important to note that a 1972 publication of the National Council on Aging, Triple Jeopardy--Myth or Reality?, continued the interest in the application of a "multiple jeopardy" concept to the minority aging experience. Although these early discussions in no way provided any true social scientific test of the hypothetical notion that by virtue of their combined statuses, minority older persons find themselves in greater need than others, they did provide a construct validation of sorts.

The nature of the minority aging research produced in 1973 continued the trends established a few years earlier. This is especially evident in the Proceedings of the Black Aged in the Future Conference, which included essays by some of the more insightful scholars and more influential precursors on matters of death and dying (Kalish), social stratification of aged Blacks and implications for training professionals (J.J. Jackson), nursing care (Penn), psychiatric strategies (Carter), housing and geriatric centers (H.C. Jackson).

The action dimension of minority aging research implied in earlier works was explicitly established with the publication of Action for Aged Blacks: When? A Conference of the National Caucus on the Black Aged in 1973. Of course, this trend has been evident to some participant observers since before the 1971 White House Conference on Aging.

The first National Institute on Minority Aging (IMA) was hosted by the University Center on Aging, San Diego State University in 1973. The papers and workshops of the first IMA reflected continued deep concern with matters of social policy (Raya, 1974), the role of minority elderly in determining their own destiny in service delivery systems (H.C. Jackson, 1974), curriculum (Beattie, 1974), along with emergent basic research (Kalish, 1974) and theory (Tobin, 1974) concerns.

At this point it might be well to note the particularly influential role of J.J. Jackson, who has remained a major force in the development of minority aging research for almost two decades now. During 1973, she was responsible for editing the two pioneer minority aging conference proceedings of the year, in addition to publishing more than a half dozen articles in professional journals and popular periodicals. In 1974, she published two status reports on the newly established National Center on Black Aged--one of which was subtitled "A Challenge to Gerontologists," just to emphasis its critical perspective. In 1975-76, J.J. Jackson established the first professional journal for specialists in minority aging, Black Aging.

The reports published in Black Aging, combined with those published in the proceedings of the Second National Institute on Minority Aging made some immediately significant quantitative and qualitative contributions to the existing literature. Another significant contribution was the proceedings of the First National Conference on Spanish Speaking Elderly (Mendoza, Gomez, and Henandez, 1975). One outcome of the conference being the establishment of the Asociacion Nacional Pro Personas Mayores as another ethnic-specific (Hispanic) minority aging advocacy organization.

Two landmark minority aging works were published in 1976: Bell, Kasshau, and Zellman's Delivering Services to Elderly Members of Minority Groups: A Review of Literature, and the Human Resources Corporation's Theories of Social Gerontology for Research and Programming by the Administration on Aging. These first efforts at preparing a comprehensive assessment of minority aging research met with some measure of success. They were able to summarize the available literature, identify gaps, and propose avenues for future study.

The Final Report on the First Indian Conference on Aging was produced in 1976, the same year that the Final Report on the First Western Regional Hispanic Conference on Aging was produced. Both of these contributed to a better understanding of the complexity, heterogeneity, and variation among minority persons, even when members of the same ethnic group.

The proceedings of the first major research Conference on Health and the Black Aged were published in 1977. Topics addressed by the presentors included hypertension compliance, prostrate gland carcinoma, mobility among the physically impaired, mental health, life expectancy, folk remedies and drug misuse.

The first Generations issue to be primarily devoted to minority aging issues was published in 1977, as were the proceedings of the National Institute on Minority Aging, Comprehensive Service Delivery Systems for the Minority Aged (Stanford, 1977). Both of these publications reflected the increased concern of minority aging researchers and practitioners with service and planning issues. A separate example is G.P. Ho's 1977 presentation before the Subcommittee on Housing and Consumer Interests of the Select Committee on Aging, "Older Americans Act: Impact on Minority Aging."

A major achievement for both theory and method in minority aging research was the completion of the pioneering research project, Social and Cultural Contexts of Aging: Implications for Social Policy by the researchers at Andrus Gerontology Center, University of Southern California (Ragan and Bengtson, 1977). It was the first project designed to include more than two comparative segments of older persons. The significance of the project's findings was immediately apparent (Bengtson, Cuellar, and Ragan, 1977; Bengtson, 1977; Grisby, Corry, and Hruby, 1977; Kasshau, 1977).

Without a doubt, the most often cited report, using data from the

USC Social and Culture Contexts project, remains Dowd and Bengtson's 1978 test of the "double jeopardy hypothesis." Although flawed, the Dowd and Bengtson work has helped to call gerontological attention to the type of hard questions that need to be addressed. Dowd and Bengtson's findings and conclusions have stimulated further empirical tests and examination of the multiple jeopardy issue (Ward, 1979; Markides, 1980; Stephens, Oser, and Blau, 1980).

The next significant advance in minority aging came with the 1978 publication of the cross-cultural aging monographs produced by the University Center on Aging of San Diego State University. These were the results of the first attempt to develop a cross-cultural study that systematically examined the conditions of minority elders in a finite area, and with some comparable method. As might be expected, this project made a number of significant contributions to the development of minority gerontology, with some of the more important ones being in the sphere of methodology (Valle and Mendoza, 1978).

Policy Issues Concerning Minority Elderly: Final Report, Six Papers by the Human Services Corporation was another important document produced in 1978. It included status reports on each of the major ethnic minority groups, and discussions of key planning and policy issues.

A cursory review of the proceedings of the 1978 conferences on minority aging reveals both an increased concern with certain specific issues, and the diverse interests of various specific groups. The Fourth National Institute on Minority Aging focused on retirement. The Second National Indian Conference on Aging focused on health concerns of the Indian elderly. And, the National Center on Black Aged's conference generated papers on the state of minority aging research and its relation to the status of training in minority aging.

The first major collection of original essays on both old and new issues and approaches in minority aging research was published in 1979. Edited by E. P. Stanford, the collection clearly reflects the advances made in less than a decade by minority gerontologists with insightful discussions on a variety of topics, including advantages and disadvantages of quantitative research (Ragan, 1979), interpretive research approaches (Korte, 1979), secondary data analysis (Moriwaki, 1979), community involvement in research (Langston, 1979), impact of minority aging research on services, (Steinberg,1979) and community (Yip, 1979), inequities (Martinez, 1979), insiders and outsiders in minority gerontology (Cuellar, 1979).

Several other important minority aging works were produced in 1979. They reflect the primary orientations in minority aging at that time. The first was a set of topical monographs edited by J.I. Kosberg for practitioners in the field, and published by the National Association of Social Workers. Another was the J.M. Colen and D.L. Soto report on the techniques of service delivery to aged minorities used by successful programs. A third example is the collection of essays edited by Gelfand and A.J. Kutzik published together under the title of Ethnicity and and Aging: Theory, Research and Policy. This latter work may come to be viewed in time as more of a contribution to the effort of Outsider gerontologists to undermine the minority gerontology movement by diluting it with "White ethnic" perspectives that shift theoretical and practical issues away from critical questions of correlates of jeopardy.

The first years of the '80s decade have witnessed an impressive expansion of minority aging research. The effort reached an ever-widening audience of concerned researchers and practitioners. The following professional journals devoted all or a significant part of their 1980 volume to minority aging research: Journal of Education for Social Work, California Sociologist; Social Casework, The Journal of Contemporary Social Work; and the Journal of Gerontological Social Work. Aging devoted one 1980s issue specifically to Hispanic aging issues.

The impact can also be noted at another level. Most new or revised major gerontology textbooks and handbooks published in 1980 included chapters or sections on minority aging. Unfortunately, most of these remain impressionistic summaries that stem from limited reviews of literature, and today appear as poor reflections of the state-of-the-art.

It is important to note that the future of minority aging research was significantly enhanced by the completed transformation of the highly specialized Journal of Black Aging to the more inclusive Journal of Minority Aging during 1980. When combined with the publication of the first minority aging textbook by one of the foremost minority scholar-activists in the field, J.J. Jackson's Minorities and Aging, and with the publication of Curriculum Guidelines in Minority Aging, it becomes apparent that minority gerontology is entering a new stage of academic development, one that may witness significant pedagogical advances.

Another significant development came in 1980 with the almost simultaneous release of the Federal Council on Aging's staff report on policy issues concerning the elderly minorities, and the report of the

Select Committee on Aging, which recommended changes in the administration and implementation of aging policies and programs that promise to eliminate or seriously reduce older minority persons' access to public benefits and services in the 1980s. The important point is that the latter totally ignored the former, and the findings of all previous reports on minority aging available to the Select Committee on Aging.

Gaps, 1970-1980[2]

Minority Aging Codification Project staff reviewed numerous bibliographies and identified 1,500 minority aging research references. Almost half of these were collected and analyzed according to subject matter and ethnic group orientation.

The content of each report was determined by reading. In addition to "ethnic-specific" reports, a good number were found that discussed or compared more than one ethnic group (multi-ethnic). Those reports that clearly did not emphasize one specific ethnic orientation were classified in the broader "minority groups" category.

Table 1 shows that almost half of the minority aging research collection referred to older Blacks, almost 30 percent to Hispanics, with slightly more than one-fifth referring to Pacific/Asians, 15 percent to American Indian/Alaskan Natives, and slightly more than one-fifth classified under the ambiguous Minority Group category.

As might be predicted from the historical trends, besides Afro-American, the specific ethnic traditions most often studied were Mexican American, Japanese American, and Native American. Those specific ethnic traditions which are least researched and understood include Alaskan

TABLE 1. ETHNIC ANALYSIS

	ETHNIC GROUP	N	% Total (N=743)	
I.	AMERICAN INDIAN/ALASKAN NATIVE	113	15.2	% AI/AN
	AMERICAN INDIAN	104	13.9	92.0
	NAVAJO AMERICAN	13	1.7	11.5
	ALASKAN NATIVE	10	1.3	8.8
II.	BLACKS	365	49.1	
III.	HISPANIC	222	29.8	% HI
	HISPANIC AMERICAN	75	10.0	33.7
	MEXICAN AMERICAN	147	19.7	66.2
	PUERTO RICAN AMERICAN	23	3.0	10.3
	CUBAN AMERICAN	13	1.7	5.8
IV.	PACIFIC/ASIAN	160	21.5	% P/A
	PACIFIC/ASIAN AMERICAN	21	2.8	13.1
	ASIAN AMERICAN	53	7.1	33.1
	JAPANESE AMERICAN	60	8.0	37.5
	CHINESE AMERICAN	46	6.1	28.7
	PILIPINO AMERICAN	29	3.9	18.1
	SAMOAN AMERICAN	13	1.7	8.1
	KOREAN AMERICAN	11	1.4	6.8
	GUAMANIAN AMERICAN	5	0.6	3.1
	HAWAIIAN AMERICAN	3	0.4	1.8
V.	MINORITY GROUPS	167	22.4	

AI/AN = American Indian/Alaskan Native
HI = Hispanic
P/A = Pacific/Asian

SOURCE: Miller-Soule, D.I., Clair, J.M., Karafin, S.J., and Stanford, E.P. "Minority Aging Research: The State of the Literature," presented at the 34th Annual Meeting of the Gerontological Society of America, Toronto, Canada, November 1981

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Native, Cuban American, and Hawaiian American.

Table 2 summarizes the ethnic content of the minority aging research literature. More than half (58.2%) of the literature was ethnic-specific research literature and, of this almost half (49%) focused on older Blacks. In addition, almost 57 percent of the multi-ethnic articles also referred to older Blacks. More than one third (36%) of the minority aging literature was multi-ethnic in focus. Again, the ethnic elderly with the greatest number of references include: Mexican American, Japanese American, and American Indian. Again, the ethnic elderly with the least number of research references include: Alaskan Native, Puerto Rican, Cuban American, Pilipino American, Korean American, Samoan American, Guamanian American and Hawaiian American.

Figure 1 displays a chronological profile of minority aging literature for the decade 1970-80. It records the significant increase in minority aging manifested during 1971; the general decrease in 1972; and the steady increase from 1972 through 1980 for references to Black aging, and from 1975 through 1980 for references to Hispanic aging. The dramatic increase in references to Pacific/Asian aging between 1976 and 1978 is illustrated, as is the also significant increase in references to American Indian/Alaskan Native aging during the same period.

Table 3 reveals the five subject areas that have received the most attention in the minority aging literature. These are public policy/legislation/legal (26.5%), literature review/overview (15.8%), health (15%), social network/family relations (13.8%), and mental health (12.6%). Generally, the areas that received the least research attention are transportation/mobility (0.4%), leisure/recreation (0.5%), and nutrition

TABLE 2. ETHNIC CONTENT ANALYSIS

ETHNIC GROUP	ETHNIC-SPECIFIC N=433 % TOTAL=58.2			INTRA-ETHNIC N=42 % TOTAL=5.6		MULTI-ETHNIC N=268 % TOTAL=36.0		TOTAL
	N	%ES AI/AN	%	N	%	N	%	
I. AMERICAN INDIAN/ ALASKAN NATIVE								
AMERICAN INDIAN	44	84.6	10.1	12	28.5	48	17.9	104
NAVAJO AMERICAN	6	11.5	1.3	5	11.9	2	0.7	13
ALASKAN NATIVE	2	3.8	0.4	7	16.6	1	0.3	10
TOTAL ES	52							
II. BLACKS	213		49.1	--	--	152	56.7	365
		% ES HI						
III. HISPANIC								
HISPANIC AMERICAN	28	31.4	6.4	10	23.8	37	13.8	75
MEXICAN AMERICAN	58	65.1	13.3	8	19.0	81	30.2	147
PUERTO RICAN AMERICAN	2	2.2	0.4	4	9.5	17	6.3	23
CUBAN AMERICAN	1	1.1	0.2	8	19.0	4	1.4	13
TOTAL ES	89							
		% ES P/A						
IV. PACIFIC/ASIAN								
PACIFIC/ASIAN AMERICAN	13	16.4	3.0	3	7.1	5	1.8	21
ASIAN AMERICAN	11	13.9	2.5	10	23.8	32	11.9	53
JAPANESE AMERICAN	28	35.4	6.4	12	28.5	20	7.4	60
CHINESE AMERICAN	13	16.4	3.0	15	35.7	18	6.7	46
PILIPINO AMERICAN	3	3.7	0.6	13	30.9	13	4.8	29
SAMOAN AMERICAN	6	7.5	1.3	0	0.0	7	2.6	13
KOREAN AMERICAN	1	1.2	0.2	5	11.9	5	1.8	11
GUAMANIAN AMERICAN	2	2.5	0.4	0	0.0	3	1.1	5
HAWAIIAN AMERICAN	2	2.5	0.4	1	2.3	0	0.0	3
TOTAL ES	79							

ES = Ethnic-Specific
AI/AN = American Indian/Alaskan Native
HI = Hispanic
P/A = Pacific/Asian

SOURCE: Miller-Soule, D.I., Clair, J.M., Karahn, S.J., and Stanford, E.P. "Minority Aging Research: The State of the Literature," presented at the 34th Annual Meeting of the Gerontological Society of America, Toronto, Canada, November 1981

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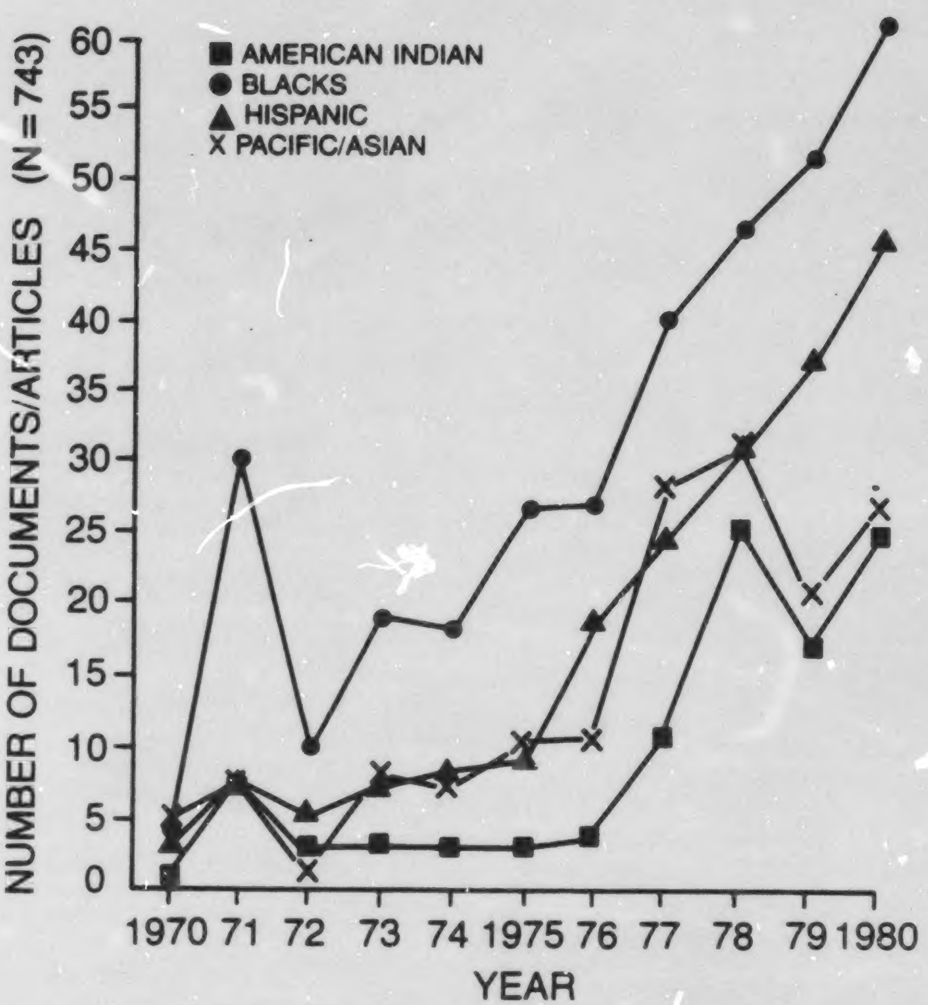
FIGURE 1. CHRONOLOGICAL PROFILE



SOURCE: Miller-Soule, D.I., Clair, J.M., Korafin, S.J., and Stanford, E.P. "Minority Aging Research: The State of the Literature," presented at the 34th Annual Meeting of the Gerontological Society of America, Toronto, Canada, November 1981

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TABLE 3. SUBJECT ANALYSIS

SUBJECT	N	% TOTAL	% AI/AN TOTAL	% BL TOTAL	% HI TOTAL	% P/A TOTAL
HEALTH	112	15.0	15.9	14.5	10.8	15.0
NUTRITION	6	0.8	0.0	0.2	0.0	0.6
SOCIAL NETWORK/ FAMILY RELATIONS	103	13.8	9.7	14.7	12.6	13.1
PUBLIC POLICY/LEGISLATION/LEGAL	197	26.5	40.7	21.9	34.2	24.3
HOUSING/LIVING ARRANGEMENTS	31	4.1	1.7	6.0	3.1	3.1
EMPLOYMENT/RETIREMENT	25	3.3	2.6	2.7	3.6	2.5
INCOME/ECONOMICS	25	3.3	0.0	4.9	2.2	0.6
TRANSPORTATION/MOBILITY	3	0.4	0.0	0.5	0.9	0.0
MENTAL HEALTH	94	12.6	10.6	17.2	14.4	7.5
EDUCATION	25	3.3	0.8	3.0	1.8	3.7
LEISURE/RECREATION	4	0.5	0.0	0.5	0.4	0.0
LITERATURE REVIEW/OVERVIEW	118	15.8	18.5	13.4	16.6	25.0
TOTAL N	743					

AI/AN = American Indian/Alaskan Native
BL = Black
HI = Hispanic
P/A = Pacific/Asian

SOURCE: Miller-Soule, D.I., Clair, J.M., Karafin, S.J., and Stanford, E.P. "Minority Aging Research: The State of the Literature," presented at the 34th Annual Meeting of the Gerontological Society of America, Toronto, Canada, November 1981.

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(0.8%).

There were no references available on American Indian/Alaskan Native elderly nutrition, income/economic, transportation/mobility, and leisure/recreation. In Black aging, the subject areas that received the least research attention include nutrition (0.2%), leisure/recreation (0.5%), transportation/mobility(01.5%), and employment/retirement (2.7%). There were no references to nutrition research found for Hispanic aging, with leisure/recreation (0.4%), transportation/mobility (0.9%), and education (1.8%) receiving very little attention. For Pacific/Asian aging, there were no references that specifically addressed the areas of transportation/mobility, or leisure/recreation. And there were too few references to Pacific/Asian elderly income/economics or nutrition.

A source analysis of the minority aging literature is presented in Table 4. Approximately one-fourth (24.4%) of the literature has been published in proceedings of conferences and meetings. Over one third (39.1%) has been published in professional journals. Approximately one-fifth (21.7%) of the research on minority aging is found in dissertations, theses, and more difficult-to-obtain project reports, unpublished manuscripts, and presentations.

TABLE 4. SOURCE ANALYSIS

SOURCE	N	% TOTAL
JOURNAL ARTICLE	291	39.1
BOOK CHAPTER	58	7.8
GOVERNMENT DOCUMENT	22	2.9
PROJECT REPORT	59	7.9
PROCEEDINGS	182	24.4
PRESENTATION	63	8.4
DISSERTATION/THESIS	8	1.0
UNPUBLISHED MANUSCRIPT	33	4.4
MAGAZINE ARTICLE	12	1.6
BOOK/MONOGRAPH	15	2.0
	—	
TOTAL N	743	

SOURCE: Miller-Soule, D.I., Clair, J.M., Karafin, S.J., and Stanford, E.P. "Minority Aging Research: The State of the Literature," presented at the 34th Annual Meeting of the Gerontological Society of America, Toronto, Canada, November 1981.

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Summary and Conclusions

Minority aging research is, in essence, a post Second World War phenomena. The same forces that contributed to the emergence of other "population-oriented" fields such as ethnic studies, women's studies, and urban studies, have affected the ways gerontology has developed as a scientific arena with its own questions, issues, methods, and objectives. The gains made by minority aging as a distinct area of specialization with social gerontology can be linked directly to the "crisis of criticism" vigorously carried on by minority social science students in the field of gerontology for almost two decades. Minority gerontology has developed in specific response to the demands of activists.

The persistent criticism of early research, particularly that carried out by Outsider researchers, has helped redefine and refine minority aging scope and method. Most minority aging researchers now agree that most of the earlier studies suffer from one or more of the following deficiencies: (1) abstracted empiricism; (2) paucity of reliable data; (3) theoretical and methodological deficiencies; and (4) failure to give sufficient consideration to the needs of minority elderly involved. The alternative appears to pay more attention to the effects and significance of ethnic community history, institutionalized racism or discrimination, and subcultural variations and changes over space and time on the subjective circumstances and objective conditions of minority older persons. Theoretical emphasis is given to questions concerning correlates of inequities and needs, barriers to and enhancers of services, correlates of heterogeniety and variation. Methodological emphasis is given to techniques and strategies that include minority older persons as active participants in the research process, and have their bases in the close rapport and ties that the Insider researcher has established with others in the community over a period of time.

"Minority gerontology" has been defined as the systematic comparative study of aging and age stratification in minority communities in order to better identify and address the needs and problems of minority older persons from one generation to the next. It is considered a viable area of specialization with a future because a number of basic conditions have been satisfied during its development. First, its body of critical and empirical knowledge has expanded exponentially, more than 1,400 documents have been generated in just two decades. The establishment of specialized journals that appeal to professionals and paraprofessionals concerned with minority older persons, as well as the increased attention given to minority aging research by editors of gerontology and other disciplinary journals, textbooks and handbooks, have helped expand the parameters of the subfield. Second, there are groups of researchers and practitioners who identify themselves as specialists in minority aging or gerontology, and who have developed persisting relations with one another--along and across ethnic lines--and established advocacy and professional organizations to help meet their needs and address their common interests. Minority aging has been institutionalized: the national advocacy organizations, the national minority research and resource centers, and the annual Institute on Minority Aging, all have contributed to the establishment of minority aging as a recognized area of specialization in gerontology.

Third, minority aging researchers and practitioners have developed a number of shared perspectives. Some of these are objectives, others are methodological standards. Most minority gerontology researchers and practitioners appear to share the following goals: (1) an increased number of minorities in gerontological work; (2) a gerontological curriculum that is sensitive to the unique historical experiences of diverse ethnic minority older persons, and makes an effort to understand and address their unique needs; and (3) established research, educational, sociocultural, and politicoeconomic action programs and service delivery systems that help solve some of the most pressing problems of minority older persons, regardless of language, education, race or religion.

In both theory and practice, minority aging studies remain a subarea of gerontology, since the basic focus always remains on older persons. Nonetheless, minority aging studies continues to develop as an arena with its own characteristics and dimensions. First, is its critical dimension that subjects dominant institutions and thought to rigorous analysis. Second, is its holistic dimension that involves multimethod approaches and multilevel analyses, ranging from the intersubjective to the institutional, from the local and idosyncratic to the international and universal. Third, is its reflexive dimension, with an analytical introspection that critically assesses the researcher's basic assumptions, biases, and prejudices, particularly those predicated on ethnocentric and/or chauvinistic logic or beliefs.

Minority aging studies also has four specific characteristics. It is comparative by definition because it aims to isolate similarities and differences between and among various segments of minority older persons. It has an applied emphasis because its findings are primarily geared toward those practitioners who provide direct services, plan programs, create and administer policy affecting older minority persons. It is transdisciplinary since its practitioners are specialists who have transcended the scope of their original disciplinary training to work in the field of aging, and specifically among minority older persons. It has a minority focus, which centers attention on the conditions and circumstances of those older members of communities that have been subjected to unfair, differential and inferior treatment, and harmed by institutionalized prejudice and systematic discrimination because of their racial and/or cultural characteristics.

The gaps in minority aging studies can be summarized as follows. Navajo American, Alaskan Native, Puerto Rican, Cuban American, Pilipino American, Samoan American, Korean American, Guamanian American and Hawaiian American older persons are represented in less than 5 percent of the literature. Since 1978, the quantity of minority aging studies on American Indian/Alaskan Native and Pacific/Asian older persons has not increased appreciably.

More than half of all minority aging literature is concentrated on the following three subject areas: public policy/legislation/legal, literature review/overview, and health. Nutrition, transportation/mobility, and leisure/recreation have received little or no attention in minority aging studies. More than half of the minority aging literature can be considered difficult to obtain.

An increase in utilization and dissemination of the minority aging literature can be accomplished through the development of more projects designed to collect and codify information, with a special emphasis on the "fugitive" (hard-to-find) literature. Given the exponential growth of minority aging studies, there is an increased need for a minority aging resource center clearinghouse to facilitate accessibility of available minority aging studies.

Some of the specific recommendations regarding research gaps in minority aging that need immediate attention include:

1. Increase research support in at least three areas of primary need among minority older persons: nutrition, transportation/mobility, and leisure/recreation.
2. Increase research on older persons in the following ethnic minority communities: Navajo American, Alaskan Native, Puerto Rican, Cuban American, Pilipino American, Samoan American, Korean American, Guamanian American, and Hawaiian American.
3. Increase the systematic dissemination of minority aging studies and service projects by creating a Minority Aging Clearinghouse and Resource Center to facilitate matters.

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[1] References cited in this chapter may be found in bibliographic section below.

[2] An earlier version of the following findings was presented in "Minority Aging Research: The State of the Literature," Miller-Soule, D.I., Clair, J.M., Karafin, S.J., and E. P. Stanford, 34th Annual Meeting of the Gerontological Society of America, Toronto, Canada, November, 1981.

A HUMAN SERVICE MODEL: FUTURE DIRECTIONS FOR AGING POLICY AND MINORITIES

The trends and direction of minority aging studies over the last few years are consistent with the Older Americans Act Amendments of 1978, Public Law 95-478. The changes mandated by some of these amendments clearly demonstrate a Congressional intent to reduce structural barriers for and increase access of low-income and minority older persons participating in programs conducted under this Act. This equitable intent was also manifested when Congress authorized the Federal Council on Aging to undertake a thorough evaluation and study of programs conducted under the Act. The study required by Section 205(g) of the Act included--

a) an examination of the fundamental purposes of such programs, and the effectiveness of such programs in attaining such purposes;

b) an analysis of the means to identify accurately the elderly population in greatest need of such programs; and

c) an analysis of numbers and incidence of low-income and minority participation in such programs.

An additional objective of the aforementioned study was an exploration of alternative methods for allocating funds in an equitable and efficient manner, which will accurately reflect current conditions and insure that such funds reach the areas of greatest needs and are effectively used for such areas.

Responsibility for implementation of the Older Americans Act rests with the Administration on Aging, State agencies on aging, and Area Agencies on Aging. In response to the amendments intended to reduce program inequities with respect to low-income and minority older persons who were in greatest need, there have been some attempts made. Since 1979 a number of studies supported by the Administration on Aging have produced findings on the means of identifying older persons in greatest need, and on the numbers and incidence of low-income and minority persons who do and do not participate in public aging programs (Colen and Soto, 1979; Cuellar and Weeks, 1980; Guttmann, 1980; Lacayo, 1980; Williams, 1980). These studies have found minority older persons to be in greatest of needs, and with limited access to public programs. These studies represent a sizeable investment of public resources. Despite this sizeable investment of money and time, implementation of policy recommendations based on the results of the studies has been a slow, painfully hesitant process. There is a move to build into the next set of Amendments new provisions that shift the attention away from those older persons in greatest need to those persons 75 years and older. Thus, it is important to call attention to some of the recent recommendations of the Select Committee on Aging presented to Congress in Future Directions for Aging Policy: A Human Service Model, particularly the following legislative changes:

> 1. ...the full floor of services must be mandated only for those who need it most, the frail elderly (75 plus) and those who have reached functional dependence before this age...we recommend raising age eligibility for certain programs from 60 to 65.
>
> 2. ...the independence of the Administration on Aging...as the agency responsible for national needs assessment, program planning, technical assistance, and information dissemination. ...removal of the disbursement authority to the Department of Treasury...
>
> 3. ...the merger of all present Title XX services to the elderly under the Older Americans Act.

The Subcommittee on Human Services' Forward to the report also highlighted the following proposed administrative changes:

1. The role of the Area Agencies on Aging as local resource centers must be strengthened especially as to planning from the bottom up and supporting and utilizing fully-in place systems, whether public--or most important of all, private, families and neighborhoods, voluntary and religious associations, and racial/ethnic subgroups.
2. Emphasis of all care systems must be reoriented to Prevention. ...Funding must be increased for research and education in such areas as early detection and self-help health.
3. The role of the state agencies on Aging must be strengthened as as well, as the link (fiscal and planning) between AAAs and the AoA.
4. ...our Human Service Model includes tacit support for the following: (1) elimination of all remaining forms of mandatory retirement; (2) rigid enforcement of age discrimination laws; (3) reduction formula for the tax rates of workers over age 65 and exemption from taxation of the first $5,000 of retirement income; (4) full tax credits for individuals or families who care for elders; (5) inclusion of specific home health component for elders in national health insurance policies. These policies will provide a support base to all human services.

As the United States moves toward the year 2000, as the "baby boom" generation enters middle life, the "G.I." generation enters later life, and the "new wave" generation enters young adulthood, there is a growing public concern with government spending and the effectiveness of public services delivery. The mood of the country reflects the view that programs for the aging should primarily be for those in greatest need, rather than for everyone who is 60 or older and wants to participate.

For this reason, the following chapters by five prominent gerontologists should be of particular interest. Based on recommendations of the four ethnic-specific minority aging organizations involved in the project, these individuals were commissioned to analyze the proposed Human Service Model, by reflecting what is known, and not known, about aging and older persons in each of the minority groups represented against the framework provided by the seven options that make up the proposed direction for future aging policy:

1. Who should receive priority for senior services?
2. Should a future service system for seniors be age-integrated or age-specific?
3. What kind of services should be involved? Should the model employ a preventive or treatment orientation?
4. The next question goes to the heart of service delivery: In our approach to human services, should we emphasize acute or long-term care?
5. What is the scope of services that should be available? Should they be limited or comprehensive?
6. Should policy making and service provision in our model be centralized or decentralized?
7. Will the many resources needed for our Human Services System be found in the public or the private sector?

Each analyst was to approach the model from an ethnic-specific perspective. Each was to address the most important aging human service issues involved, and discuss possible implications of the proposed Human Service Model for older persons in their primary minority groups. The analysts had access to available codification project literature, although it should be noted that the uneven quantity and quality of research available on the different subjects and specific ethnic minority older persons made their task that much more difficult.

To provide a perspective for succeeding chapters, the Introduction and Summary of the report, Future Directions for Aging Policy: A Human Service Model (1980), by the Subcommittee on Human Services, Select Committee on Aging are presented below. These reveal some of the basic assumptions that guide their Human Service Model. Following the ethnic-specific reflections on the proposed model, a cross-cultural summary with broader minority aging conclusions is presented. The summary will highlight the important shared perspectives and variations on themes.

FUTURE DIRECTIONS FOR AGING POLICY: A HUMAN SERVICE MODEL*

Aging in America is a success story. Because of great improvements in health conditions--few women die in childbirth, and infectious diseases have been generally wiped out--life expectancy has increased dramatically. More Americans live to be old, and older Americans are living longer. In addition, because the postwar baby boom will eventually become a senior boom, the proportion of seniors in the overall population is sure to reach significantly higher levels.

Conventional wisdom sees this population transformation as a problem--the so-called "greying of America." In this view the senior population is a burden, a drain on the economy, and a menance to our well-being. We, of the Select Committee on Aging, however, see the growing numbers and proportions of seniors as a triumph--one for which this country can be justifiably proud. But every cultural advance is a double--edged sword; together with the benefits, there are disruptions. An aging America is no exception.

The question then is one of perception. The way we frame an issue today determines how we handle it tomorrow. If, for example, in our public policies on aging, we -

> define older persons as separate from the rest of the adult population, base this segregation on the attainment of a predetermined age (65), assume that precisely at this age certain disabilities are inevitable, and then forget that we ourselves set up this arbitrary system,

we have effectively turned a natural process into a national problem. We have manufactured what Alex Comfort calls "sociogenic aging"[1]--the role society imposes on people as they turn 65. By a policy of stereotyping, segregation, paternalism, and amnesia, we have created the "problem" of old age, and have been forced to deal with it through what has accurately been labeled the "Aging Enterprise."[2]

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*Excerpt directly from A Report by the Subcommittee on Human Services of the Select Committee on Aging, U.S. House Of Representatives, U.S. Congress, Comm. Pub. No. 96-226, U.S. GPO, May, 1980.

[1] Comfort, Alex, A Good Age, New York: Crown, 1976

[2] Estes, Carroll, The Aging Enterprise. San Francisco: Jossey-Bass Inc., 1979.

As the size of this "problem" segment of the population increases and the cost of legitimate services escalates, we run flat into a crisis of care: we can no longer afford to deal with the problem we ourselves have manufactured and end up blaming the victims. What is actually a triumph has become a tragedy--the problems of old age in America.

As a result of the comprehensive study that resulted in this report, this committee takes a completely different tack. Because our perception of the issue is different, it is our intention to demythologize this problem of old age by--

returning older persons to their rightful place in the adult world,

refusing to allow segregation based on chronological age,

fostering independence as the goal for all adults, wherever and as long as possible,

providing a full floor of services for those elders who have become dependent, and

empowering available natural support systems to provide the bulk of such services at the local level.

OUR REPORT, IN SUMMARY

Aging in America has changed. The meaning of the word, the size of the senior population, indeed the very process of aging itself--all have undergone radical transformations in the 20th century. So rapid and so pervasive are these changes that policy makers and public policies have barely kept up. In fact, some critics think that present policies and programs have not kept up at all, that they deal with America's aging dilemmas in only a symbolic and fragmented way. Public officials have responded, to be sure, but the responses have been far short of the mark, more rhetorical than real, more kneejerk in development than thoughtfully planned out--amounting to no coherent policy on Aging in America at all.

Another view states that since the 1930s our nation has responded to its seniors in a heroic way, first with financial aid (Social Security), then health care (Medicare and Medicaid), and finally with a raft of service programs in America, but its development has been zigzag and its results so massive that America's care for seniors is threatening to "burst the budget".

Whatever the actual merits of today's policies and programs, there is general agreement that the future of Aging will present an even greater challenge to policy makers. Trends we see only dimly today, pressuring as they do almost every social and economic structure in our nation, will completely unfold in the near future. Will we be prepared to accommodate to a populace that is more senior than junior? Whose "baby boom" generation will transform itself into a "senior boom"? To a nation where virtually all the major causes of death will be eliminated and whose citizens may well live to the venerable age of Methuselah?

And who will pay the bill? Will policy makers be able to chart a course between austerity and fiscal restraint on the one hand (in response to not so gentle urgings from the citizenry) and still meet legitimate service needs on the other? What about the oldest group in our society--those 75 and over; they are the fastest growing, most needy, and costliest segment of the population. How will we accommodate to them?

Such questions must be addressed with prudence and candor. Traditional political expediency (the habit of muddling through) seems short-sighted when the issue is tomorrow's enormous senior population. What is needed today is a foresighted approach[1] to aging policy--a sober analysis of current trends, a realistic assessment of where these trends will lead, and development of a policy course that is compatible with the realities.

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[1] For a discussion of the increasing role of Foresight in Congress, see Appendix 1.

This, then, has been the goal of our subcommittee. In a foresighted way, we first looked at current demographic trends. Data from the U.S. Bureau of Census indicate that as a nation we are growing older--more people are living longer. At the same time, because our society is gradually settling into zero population growth, the number of births is decreasing. Demographically this is significant because it means that the proportion of seniors in our population is mounting.

It is also clear that being old in America is not a homogeneous experience. A conceptual distinction is now being made between "young-old" (55-75) and "old-old" (75+). As a group, those 55-75 are relatively free from traditional social responsibilities of work and family, and are relatively healthy, well-off, and active. The old-old, on the other hand, are poorer, sicker, less educated, and more likely to be dependent on family, friends, community support, and the government. Projections tell us that this latter group is the fastest growing segment in our population!

In checking the reliability of these trends, we have discovered that there is a high probability that current demographic data will have to be revised upward. Research shows that the three greatest death-causing diseases in America - cancer, stroke, and heart attack - will probably be overcome in the next 50 years. Since their greatest toll is taken among older Americans, the greatest benefit in terms of added years will also accrue to the senior population.

In addition, there is mounting evidence that aging itself - that underlying non-disease biological process - is coming under scientific control. While there is little agreement about when this might happen, there is virtual unanimity that the "aging clock" will be understood and probably retarded. It is only a matter of time and money.

These three trends - demographic, biomedical, and gerontological - shape one horn of an emerging policy dilemma - America is indeed becoming a Nation of Seniors.

Second, we considered the financial needs imposed by the drastically changed demographic compositon of this nation. Every possible preditor indicates there is not enough money available (given present policy priorities) to meet the needs of today's seniors, let alone tomorrow's. All levels of government - federal, state, and local - have elaborated incredible programs of human care for seniors but have seriously overextended themselves in the process. Just as this situation has been realized, the mood of the populace and the response of governments throughout the nation has turned to austerity, cutbacks, and limitations, even in human services to seniors.

This forms the other horn of an aging dilemma - the fiscal resources necessary to meet tomorrow's increasing needs are in fact decreasing.

This human service dilemma presents a serious challenge to legislators. Simplistic solutions - cut back the services or increase the funds - will not, in fact cannot, solve the problem. Only a bold creative step, a radical rethinking of the problem in new manageable terms will get us off the horns of the dilemma. Fine tuning is out of the question; a major overhaul is called for. We offer, therefore, "The Future of Aging Policy - A Human Service Model."

We started with a review and an attempt to evaluate the present service system for seniors. After extensive hearings, studies, and surveys, our worst fears were realized - although we spend about one-fourth of the federal budget on care for today's seniors, not to speak of the involvement from 80,000 other distinct governments, thousands of hospitals, nursing homes, and health and social service agencies in both the private and public sector, few of the aging issues have been resolved. The so-called aging enterprise, our traditional solution, is part of the problem, described as "fragmentation and frustration," "more confusion than assistance" throughout our hearings. What exists is a bewildering maze of policies, programs, regulations, and services - a senior jigsaw puzzle. Our survey by questionnaire from the field overwhelmingly confirmed these findings. Bringing sense to this broken mosaic via incremental policy adjustments seemed futile. It all pointed to the need for a human service strategy, constructued anew from the bottom up.

At the base of such a service approach must lie an economic strategy. We have sketched such an economic base in Appendix 5. It is designed to coalesce around work and income. Tomorrow's seniors will want to work (trends toward early retirement are already reversing according to a recent Lour Harris poll), will be capable of working, and will need to work. Inflation's effect on fixed incomes will see to that. Public policy will have to create opportunities to work, both by removing barriers of age discrimination and by stimulating private sector employment of seniors. Moreover, income earned will have to be preserved for much longer than ever before, necessitating major reform of America's penison systems. Social Security and Supplemental Security Income, because they are the backbone of our present economic strategy, will probably have to be restructured in the future. Whoever redesigns this economic strategy will have to take into account, as we had to, the two horns, demographic and fiscal resource, of the dilemma facing our nation.

We are convinced, however, that income assurance alone is clearly insufficient to meet the legitimate needs of tomorrow's seniors; it must be supplemented by a human service strategy.

We determined, therefore, to delineate each of the most important issues involved in human services to seniors, to honestly face the problems posed by each, and to look at the pros and cons of different solutions, keeping scrupulously close to present facts and future trends. As we reviewed in this way the present state of America's service system for its seniors, a series of options emerged - clearcut, relevant choices covering every aspect of such service. This committee has made a determination in the case of each option. This report is organized around these determinations, the sum of which comprises a coherent, research-based, future-oriented policy on aging - our Human Service Model.

HUMAN SERVICE MODEL

OPTION ONE[2]

Who should receive senior services?

A survey of the general goals of adult life reveals that adults strive to be independent, i.e., have a sense of contribution and overall well-being. If we analyze this sense into its components, we find that people function in five different areas: physical, mental, social, economic, and ability to perform the tasks of daily living. In each of these, an adult is independent or dependent to a greater or lesser degree. Generally speaking, those below age 75 are more independent than those 75+. In fact, data show that some forms of functional dependence are manifest in most persons at about 75+. Because this age group is the fastest growing segment of our population, it is the target group that presents the greatest challenge.

But what about the rest - all the senior citizens of 65+ heretofore lumped into the group labeled "old"? It is our contention that if this country attempts to serve all seniors equally through its fragile Aging Network, it will actually be able to serve only a few, and not very well at that. Our policy must realize that those truly in need - the 75+ population - have first rights and must be the focus of future aging policy.

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[2] For a fuller discussion of Option One see Chapter IV.

OPTION TWO[3]

Should a future service system for seniors be age-integrated or age-specific?

This question led to studies in the newly emerging field of human development that described a natural scheme of life cycles common to all persons. We learned that chronological age (by itself) is not at all a good predictor of need, and therefore not a reliable criterion for service delivery, which could be based more reliably and scientifically on the natural seasons of life, during which life changes actually occur.

Most remarkably, we realized that age 65 does not mean "old" - that equation must now be looked at as an anachronistic stereotype. In fact, at age 65, a person is just entering what seems to be "senior adulthood," a season that probably lasts 15 years, to be followed by a period of slowly increasing dependence, which we have called "elderhood". This may well be the last into the 80s and 90s, or if aging itself is overcome, indefinitely.

These two natural seasons of life - senior adulthood (about 60-75) and elderhood (about 75+) - have become the guidelines for our service model. We have chosen them because they take into consideration functional dependence, which in all cases is a much better indicator of need than chronological age. Based on this presumption, we feel that senior adults can and should be treated as functionally independent and included in ongoing adult services when the need arises. This is an age-integrated approach that is coherent with life cycles. For elders, on the other hand, we must make the opposite presumption, that they will become more dependent as time goes on and therefore will need special care. Comprehensive services should be available to them (and to anyone who may slip into functional dependence, even at an earlier age). This would be our age-specific approach. Such a two-tiered service strategy should be part of a general service continuum for all adults, starting with middle adulthood (40-60) and continuing throughout life.

Our choice, relative to Option Two, is now clear. The senior population is not homogeneous; senior adults (60-75) can be presumed to be independent and therefore should not be served separately. Elders (75+), on the other hand, probably tend to functional dependence and should therefore be served separately.

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[3] Option Two is discussed fully in Chapter V

OPTION THREE[4]

What kind of services should be involved? Should the model employ a preventive or treatement orientation?

Our studies indicate that the preventive approach in social as well as medical programs is long overdue in this country. Not only do we need it as the underpinning for a lifelong service continuum, but as the conceptual base for the comprehensive approach we advocate next.

Preventive programs should be available to all adults. Primary prevention (promotion/maintenance of independence) and secondary prevention (early detection/treatment) are the mainstays of this approach and relevant to assistance in all components of independence. Without prevention as an integral part of service programs, the service sector will be overwhelmed with unnecessary and costly expansion of treatment programs. We have therefore come down squarely on the side of prevention, as a foresighted element in our Human Service Model.

OPTION FOUR[5]

The next question goes to the heart of service delivery: In our approach to human services, should we emphasize acute or long-term care?

As people's well-being slips and independence wanes, the need for services increases. Generally, in later life, problems are chronic and the services needed, longer term. While our country has a long history of service, it has generally been in answer to acute needs. This is certainly a necessary part of the care continuum but by no means the greatest. What has been overlooked is comprehensive care - the committment to meet service needs as they change over time. This is particularly necessary for our target group of elders - their problems are generally more chronic, though sometimes quite acute. Both types of care are important, depending on identified needs. Service strategy in this country has been traditionally oriented toward acute care, but we now emphasize and have designed a long-term, comprehensive strategy, including acute care, for tomorrow's elders.

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[4] Option Three is described more fully in Chapter VI

[5] A fuller discussion of Option Four may be found in Chapter VII

For those younger, healthier, and more independent senior adults, assessment would be available. If services for acute care were needed, they would be actively referred to existing adult services; personal advocacy efforts would guarantee their inclusion in America's adult service system.

OPTION FIVE [6]

What is the scope of services that should be available? Should they be limited or comprehensive?

In our view, services to senior adults should be limited; to elders, comprehensive. Since senior adults are to be included in the continuum of adult services, they need only assessment, active referral, and advocacy services. Since the aging network will eventually deal with them as elders, it should be involved in these three roles.

On the other hand, elders (or any senior adults who are functionally dependent) should have comprehensive care, a full floor of services. The pillars of the system are outreach, evaluation, and case management by the aging network. This would guarantee the appropriate package of services needed at any given time. A continuum of care would be available including community services (family care, congregate and home-delivered meals, chore/homemaker services, day activities in centers and day care, personal care and home health care) as well as institutional care (including intermediate/skilled nursing homes and hospice care).

OPTION SIX[7]

Should policy making and service provision in our model be centralized or decentralized?

Clearly, the principle of subsidiarity is central to this endeavor. The burgeoning federal mechanism has not worked to the benefit of seniors in need. We therefore emphasize decentralization - a return to local authority, wherever possible, for planning, coordination, and delivery of human services. In fact, the system mandates whatever is needed to return our limited fiscal resources directly to those involved in the service even - seniors in need and service providers.

[6] Option Five is fully discussed in Chapter VIII

[7] Option Six is fully discussed in Chapter IX

At the local level, senior adults in need would be included in existing adult services. To guarantee this, the necessary assessment, active referral, and advocacy must become the responsibility of local Area Agencies on Aging. After all, the great majority of senior adults will reach age 75 or slip into functional dependency before age 75 - and both of these groups are the direct and major responsibility of tomorrow's AAAs. It seems logical then that the AAAs be involved to some degree with senior adults before that time as well.

But the major service responsibility of the local AAA is with elders. Here a systematic outreach is required, complete evaluation needed, and case management, where appropriate, should also be the complete aging resource in the community, available for consultation and training of anyone interested in participating in human service delivery. In this role, they would be responsible for community needs assessment and for coordination of services. To carry out these responsibilities they should use, wherever possible, community based multiservice centers.

Fiscal implementation is a different problem. In line with the principle of subsidiarity, funding for services should go directly to the states from the Federal Treasury and from the states, as pass-through agencies, to service providers. Technical assistance and money management are incompatible roles. The aging network should be the technical experts on Aging (AoA at national level, and AAAs at the local level). Distribution of monies should take the form of direct grants to states.

This would take place in two ways, in line with our two-tiered service system. Adult service monies would be consolidated at the federal level and distributed to states in block grants on a per capita basis, with a weighted factor for senior adults (60-75). Elder services monies (for the full floor of comprehensive care) would be distributed to states thorugh the Older Americans Act, the categorical grant for care to elders. States would distribute elder services money according to their State plan, designed in conjunction with local AAAs.

For instance, local groups who desired federal monies would consult the AAA for technical assistance (How do we build a center? Is it duplicative?, etc.). The AAA would present the request - in an advocacy way - to the local Council of Governments, where full debate regarding local needs would take place. The Council of Governments would send the proposal to the appropriate State Aging Agency with the recommendation that it is technically correct (AAA) and in accord with local planning. The Federal money would be distributed by contract directly to providers.

At the federal level, the Administration on Aging would become the national resource on aging - consultant to Congress on policy and to the aging network for technical assistance. It would be relieved of the onus of managing millions of dollars in grants so that it could fulfill its Congressional mandate to be the advocate for America's older population.

OPTION SEVEN[8]

Will the many resources needed for our Human Service System be found in the public or the private sector?

Since the main source of the failures in service to seniors lies with the mounting superstructure of public institutions and agencies and their inability to deliver appropriate care, we emphasize the private sector across the board. People generally derive more meaning in their lives and identity strength from personal involvements. This is especially true of America's seniors. Over, and in many ways against, these private involvements have stood public institutions - government organizations usually staffed with civil servants. Our human services model leads to reempowering those in-place service groups closest to people - the community based, care-giving structures we call "natural systems", eloquently examined by Peter Berger[9] as "mediating structures". The first and most important of these is the family.

THE ROLE OF THE FAMILY

Our research, contrary to the conventional wisdom about the wholesale abandonment of seniors by their families, shows that the family was, is, and probably will continue to be involved deeply with its seniors. Eighty percent of the home care for those 55 and over is given by family members residing in the household. What is remarkable is tht this has been done without support from - and in some cases in spite of - the public sector.

We take the opposite tack. To empower families, tax breaks in the form of credits should be established. This will be only the beginning, however, because families in the future may well be three, four, and sometimes five generational. New and creative policy initiatives will be necessary if the family is to withstand the stresses of supporting a more senior population. We see it as the public sector's role to minimize this stress and help families take care of their own in the future. This must include special consideration of the role of women - traditionally the central caregivers in the home, and statistically of greatest longevity.

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[8] Option Seven is fully discussed in Chapter X

[9] Berger, P. and Neuhaus, R., To Empower People, Washington, D.C.: American Enterprise Institute, 1977.

When families falter, what are the alternatives? Immediately the problem rises of too few fiscal resources to meet tomorrow's too many senior needs. But if we look around, we find innumerable other human resources available that have been simply ignored in the pellmell development of federally funded public sector services. These are the natural caregivers, and their existence leads us to take serious issue with the view that only professionals should be involved in human care. At best, professionals should be needed only at the serious, more complex, and costlier end of the well-being/care continuum. At virtually every other place on this continuum, natural caregivers, already in place throughout the country, are willing, able, and now more-than-ever needed. They too must be empowered.

NEIGHBORHOODS

Neighborhoods and neighborhood groups come to mind first. The world of seniors is usually bounded by their known neighborhood. This is where they walk, this is where familiar faces reside. Yet neighborhoods have been all but forgotton in the inexorable annexation that has ultimately led to cities and states. Neighborhoods can be the first line of support when families falter. Neighborhood groups are already in place across our nation and could be brought easily into the service effort.

VOLUNTARY ASSOCIATIONS

The voluntary sector is known to provide about $80-100 billion worth of services to America. Something like 6 to 10 percent of this goes to provide services to seniors. This has been accomplished generally without the support of the public secotr. How can this be reversed without the government's taking over the singularly effective efforts of volunteers? Once again, new relationships are called for. These would include, but not be limited to, tax breaks.

RELIGIOUS GROUPS

In like manner, we find prodigious resources available - and generally untapped - in the religious community. For too long we have neglected the efforts of organized religion in caring, mostly on a nonsectarian basis, for America's seniors. Every mindful of the legitimate separation of church and state, we see church-based organizations as another large and readily available source of human services.

ETHNIC GROUPS

Racial and ethnic subgroups also offer a natural support system in our communities. It is generally difficult for any majority culture to recognize and sensitively collaborate with minority subgroups. We must recognize the legitimate differences among racial and ethnic subgroups - especially in their senior populations. We therefore call for the creative use of the service potential in natural community-based minority groups, as they are closer and more aware of the culture differences that matter to minority seniors.

CONCLUSION

In sum, the model, formed by this committee's decision vis-a-vis seven policy options, provides guidelines that will resolve the two-horned dilemma facing future human services to the elderly. Furthermore in opting for services that emphasize 1) the full floor for those persons 75 years plus - within a 2) continuum of care that makes services available to all - with a 3) preventive or treatment 4) acute or long-term, 5) comprehensive or limited orientation as needed - 6) decentralized in organization - 7) utilizing fully the resources of the private sector, our plan for future policy adheres fully to the Congressional intent outlined in the 1978 amendments to the Older Americans Act.

Our model is presented visually in Figure 15, page 84, of this report (attached). In the following chapters will be found the background and the studies supporting each of our seven policy decisions in our earnest desire to bring the best in human services to those who most deserve them - our nation's elderly citizens.

AMERICAN INDIAN AND ALASKAN NATIVE ELDERS:
A POLICY CRITIQUE

John Red Horse, Ph.D.

This chapter examines public policy in aging with particular attention given to the impact policy may have upon American Indians and Alaskan Natives. Discussion is guided by the framework offered in the Future Directions in Aging Policy: A Human Service Model.[1] First is initial overview of the functions of policy with reference to the ordering of institutional priorities based upon social forecasting. This is followed by specific treatment of the Model as organized into three units: (1) age related factors, (2) service strategies, and (3) organizational strategies. Each unit is examined in light of related literature and concerns of key informants. The conclusions put forth a commentary on selected implications for research, education, and training.

Functions of Public Policy

Public policy fosters a course of action through a set of principles which guide institutional behavior. It is organized according to national priorities, thereby influencing appropriations, regulations, and interventions. Public policy may be divided into two broad, though not mutually exclusive categories: (1) reactive and (2) proactive.

Reactive policy is ameliorative. It evolves after problems are observed and guides corrective or compensatory interventions through institutional responses that provide social or economic supports, such as Aid to Families with Dependent Children. Reactive policy seldom attempts to solve chronic social problems, rather it insures the "truly needy" an entitled level of support for daily living.

Proactive policy is quite different in character and intent. This type of policy, following Gil (1970), anticipates relationships among individuals as aggregate units, forecasts future roles, statuses, and needs among the population, and launches resource distribution plans accordingly. Proactive policy, therefore, initiates national priorities and influences future quality of life in the United States. In other words, it is designed ostensibly to avert chronic social problems. It encourages primary prevention and highly effective secondary intervention.

The Model, proposed by the Select Senate Committee much to its credit, clearly represents proactive policy. Prediction through social forecasting, however, raises serious questions regarding appropriateness of the Model for American Indian and Alaskan Native populations. The Model is predicated upon trends derived from analyses of demographic, biomedical, and gerontological data. Clearly, errors of omission prevail.

Through analyses of census data the Model anticipates a society that is proportionally growing older and establishes an old-old cohort, i.e., 75+, as the fastest growing segment in society. Literature specific to American Indian and Alaskan Native populations, however, points to an opposite trend: they are represented by a generally young population. Estimates of median age for America Indian and Alaskan Natives are approximately 17 years while that for Whites ranges from 28 to 30 years (Benedict, 1971; Hill and Spector 1971). Moreover, life expectancy rates among American Indian and Alaskan Native elderly are significantly lower than for the White population (Human Resources Corporation, 1978). Life expectancy rates among American Indians and Alaskan Natives have increased dramatically in recent years; however, this can hardly be construed as a trend. Life expectancy rates tend to fluctuate from year to year among all population groups. A variety of medical and socio-environmental circumstances make this fluctuation more dramatic among American Indians and Alaskan Natives (Bell, Kasschau, and Zellman, 1976).

The age trend factor is exacerbated by death phenomena. There is some correlated data across the population groups that show heart disease stroke, and cancer are leading causes of death. Proportionally, however, diseases of the heart, stroke, and cancer account for only 53 percent of deaths among American Indian and Alaskan Native groups compared to 75 percent among Whites (Benedict, 1971).

Other causative factors of a compelling nature emerge. For numerous years accidents have represented the leading cause of death among American Indians and Alaskan Natives. This should not prove surprising given their hazardous social circumstances common to rural poverty (Bell Kasschau, Zellman, 1976). Chronic illnesses whether poverty related or not, contribute disproportionately to mortality rates among American Indians and Alaskan Natives as compared to Whites: cirrhosis of the liver, 5 times higher; influenza and pneumonia, 2.5 times higher; diabetes mellitus, 2.5 times higher; tuberculosis, 8 times higher. Any institutional planning for preventive health care for American Indian and Alaskan Native elders must obviously account for these population specific morbidity factors (Human Resources Corporation, 1978).

Ascertaining trends among American Indian and Alaskan Native populations through census or other government counts is a tentative process at best. Estimates of proportions of elders among these groups vary from less than 5 percent (Benedict, 1971) to 11.6 percent (Manson, 1980). A variety of reasons may account for the variations. These range from the operational definitions used to determine Indian and Alaskan Native status to degree of effectiveness of data collection procedures. The Bureau of Census methodology in 1970, for example, included Indians living only within 115 reservation areas. Indians on trust lands outside reservation areas were categorically excluded. Moreover, a tracking of the

Social Security Administration's benefit statistics for 1975 revealed that the racial classification, American Indian, was omitted (Human Resources Corporation 1978).

The aforementioned issues are not raised to criticize the concept of model-building in public policy, but rather to articulate that social forecasting is dependent upon input data for projections. Omission of representative data reflecting life circumstances among American Indian and Alaskan Native populations suggests that planners and decisionmakers have proceeded with policy formulation in a one-dimensional manner. It is obvious that new data inputs are necessary. The Model represents a mainstream statement which, without specific protective provisions, such as fiscal set-asides for culture and population specific programs, will undoubtedly place American Indians and Alaskan Natives at a disadvantage and quite possibly outside the protection of social regulations. With this general thought in mind, let us turn attention to the particulars of the Model.

Age Related Factors

Age-related factors of the Model address two critical questions: who should receive senior services, and should a future service system for seniors be age-integrated or age-specific? Areas of mental, physical, social, economic, and daily task capabilities are identified as units by which functional independence can be evaluated.

Chronological age per se is discarded as a predictor of need except at 75 years of age. A "natural seasons of life" is presented as more logical in today's society whereby senior adults (60-75) are presumed to be functionally independent persons and elder adults (75+) are presumed to be functionally dependent persons. Individuals in the senior adult stratum might qualify for services but these would be age-integrated with adult services in general and would entail elaborate screening procedures.

Elders (75+) would be served separately. Moreover, because the elderhood cohort (75+) is identified as the fastest growing segment of the American population, it rightly serves as the priority target group: the 75+ cohort has first rights and represents the focus of future aging policy.

These propositions advanced by the Model pose alarming threats to the well-being of American Indian and Alaskan Native elders. Presumptions around the target group (75+) are especially onerous. The aging process is a dependent variable and varies among population groups according to life circumstances. Recent research has drawn attention to significant differences in the aging process between American Indians and Alaskan Natives as a group and non-Indian populations. The National Indian Council on Aging (NICOA, 1981) investigated life conditions among American Indian and Alaskan Native elders and compared these with a baseline non-Indian population from Cleveland, Ohio. Two major research findings around character of life and the aging process were:

> The character of life for Indians and Alaskan Natives aged 45 and older is significantly different than that of the dominant population.
>
> Impairment levels of Indians and Alaskan Natives 55 and older are comparable to Cleveland elderly 65 and older. Rural Indians and Alaskan Natives 45 and older are comparable to Cleveland elderly 65 and older (p. 31).

These findings suggest a need for cultural adjustments around the "seasons of life." The critical period for prevention and early identification among American Indian and Alaskan Native populations appears to be 45 to 65 years of age. Excluding these years from priority focus in future aging policy places elders within these populations into "quadruple jeopardy:" they are poor, old, minority, and members of sub-populations with a wrong age distribution vis-a-vis the general population. American Indian and Alaskan Native elders become old before the proper chronological age: far too many never arrive at the "season of life" to qualify as a priority. First Americans will seldom benefit from "first rights."

The "character of life" finding by the NICOA deserves further comment. Table One identifies selected concerns raised by American Indian and Alaskan Native key informants regarding services provided for elders in these respective populations.[2] These represent time and again repeated, ubiquitous, and compelling cultural issues emanating from tribal people with distinctive characters of life.

TABLE ONE

AGE, ASSESSMENT AND EVALUATION FACTORS IDENTIFIED BY AMERICAN INDIAN AND ALASKAN NATIVE KEY INFORMANTS

*Historical Experience

*Inconsistency of Service Networks in Adapting to Cultural Differences

*Culturally Insensitive Intake Systems and Procedures

*Need to Honor and Work with Spiritual Beliefs

*Need to Lower Age Eligibility Requirements

*Culture Shock in Nursing Home Services

*Clan and Kinship Behavior

*Cultural Weighting of Eligibility Criteria

*Define Eligibility According to Tribal Standards

*Provide for Unmet Nutritional Needs

*Need for Interpreters

*Staff Programs with Indian Administrators and Line Workers

These cultural factors transcend physical and emotional deprivations that American Indians and Alaskan Natives entering the critical years of life, i.e., 45-65 years of age, have endured through chronic disease, chronic unemployment, and chronic sub-nutrition. Character of life introduces a complexity of tribes, a strength of families, and a dramatic resistance to health and social services controlled by non-Indians. Each of these impact the activities implied in the Model which are required to make distinctions around the "seasons of life," i.e., evaluation of functional independence, needs assessment, and the setting of eligibility criteria and launching of intake systems.

The complexity of tribes introduces issues of legal status and differences in cultures, languages, and historical experiences. There are 293 federally recognized tribes and 58 without such legal status. According to life style factors, these tribes may be organized into 9 to 17 separate cultural areas with 149 distinct languages generally spoken on a daily basis by elders (Manson, 1980). Language appears as a significant issue in the delivery of health and social services. Thirty-six percent of American Indian elders speak only native languages (American Indian Nurses Association, 1978). One source suggests that less than 3 percent of reservation elders are proficient in the English language (Native American Consultants, Inc., 1978). Dukepoo (1980) surveyed elders in Southern

California and noted that 49 percent of the reservation sample experienced difficulty with English language forms. Finally, the social history of tribes guides a strong sense of belonging and community aspiration. A strong identification with tribe and custom represents an unresolved issue with the aging service network. Lustig (1977) indicated much dissatisfaction in nursing homes among Indians who were uprooted from their tribal communities and randomly placed with elders of other tribes.

Community and tribal preferences are reflected through a tight-knittedness and strong bonding in American Indian families. Red Horse et al. (1976) identify a particular set of strengths organized around traditional structural patterns of extended family and kinship systems. These strengths impact both social and health behaviors. The NICOA study (1981) provides further insights into the intensity, frequency, and types of daily interactions characteristic of elders within family sytems as well as the close proximity of family members. Family structure clearly influences "level of perceived need, awareness of available services, and actual use of said services" (Manson, 1980, p 20). Kniep-Hardy and Burkhardt (1977) suggest that extended family and traditional religion must be integral to intake and diagnostic procedures and to the delivery of medical services designed for Navajo patients.

The Model, of course, does not include substantive assurances that cultural and tribal specific adjustments to facilitate early identification, rapid assessment, and treatment will assume priority status.

Service Strategies

Service strategies of the Model address several critical questions: what kind of services should be offered, should a preventive or treatment orientation be employed, should acute or long-term care be emphasized, and should services be limited or comprehensive? Primary prevention, i.e., promotion and maintenance of independence, and secondary prevention, i.e., early detection and treatment, represent mainstays of the Model. Prevention is cited as a long overdue strategy to bolster a well-planned lifelong and comprehensive service continuum. A comprehensive service continuum represents a commitment to revise care as service needs change through the course of life. Thus, acute and long term care will be tailored to benefit the targeted elders (75+). Services to younger groups are based on assumptions of limited needs, emphasizing assessment, referral, and advocacy. The pillars of comprehensive care, i.e., outreach, evaluation, and case management, would be reserved as unconditional activities for the 75+ population group. Community services and institutional care are included in the comprehensive service package.

These propositions of the Model presume that an effective institutional arrangement of health care and social services is in place. All that remains is strategic refinement through which senior adults (60-75) would receive full floor comprehensive services. In the case of American Indian and Alaskan Native populations, the obvious and critical question is ignored: How will referral and advocacy effectively serve elders who are not now reaping benefits of minimum care and have probably never enjoyed full services for which they qualify? This becomes of particular concern since the Model proposes to remove these elders from the "presumed need" list and yet places another barrier between them and mainstream quality of care by virtue of age criteria.

Equality of opportunity is a common argument advanced by American institutions. Agency personnel glibly suggest that health and social service institutions are designed to serve the entire population. Efforts and results to date have been less than satisfactory. In basic public assistance service, for example, underutilization commensurate to need by American Indians appears common in all regions of the United States (Bell, Kasschau, and Zellman, 1976). American Indians demonstrate more reluctance to use community mental health centers than other populations and in cases where visits are made, show a significantly higher dropout rate than other patient groups (Sue, 1977).

Table Two identifies related concerns raised by American Indian and Alaskan Native key informants regarding problems in service delivery to elders. These issues include network behavior, elder involvement in programs, and comprehensive care strategies. These

Table Two

SERVICE STRATEGY ISSUES IN PREVENTION, TYPE OF CARE, AND COMPREHENSIVENESS IDENTIFIED BY AMERICAN INDIAN AND ALASKAN NATIVE KEY INFORMANTS

*Need Culture Based Institutional Care

*Religious Freedom

*Develop Re-Entry Strategies Back to Family

*Develop Nursing Homes on the Reservation

*Observe Network Behavior Within Tribes Villages, and Indian Organizations

*Support Indigenous Networks to Prevent Premature Institutionalization

*Create Elderly Board of Investigators to Accredit Institutional Care

*Support Elder to Elder Services

*Train Elders in Program Planning, "onitoring, and Evaluation

*Develop More Parallel Services

*Adapt to Tribal Remoteness

Eliminate Population Requirements of Title V

*Eliminate Barriers to Coordination

*Develop Age Integrated Cultural and Educational Centers

*Develop Model Projects Designed to Track Effective Service to Elders

*Expand Community Health Representative Force

*Expand Training for Indian Professionals concerns also represent a modest and polite effort to articulate minimum cultural features necessary for a comprehensive strategy in aging policy. Modern institutional norms do not coincide with traditional Indian views concerning health and mutual aid. This has fostered "dis-ease" and underutilization.

Dukepoo (1980) identified fear and mistrust among Indian clients as fueled by insensitive agency personnel as major barriers to service delivery. Little and Shoop (1976) suggest that one strategy to relieve the "dis-ease" of fear and distress in institutional care of elders would be to provide Indian staff for service delivery. This strategy appears supported in a community survey among Minneapolis urban Indians who overwhelmingly indicated preferences to be served by Indian personnel (De Geyndt, 1973). Needless to say, American Indians "dis-ease" fosters a level of health well below American standards in general.

Elder American Indian consumers have witnessed viable alternatives designed to fit cultural customs. Nevada, for example, has a modified institutional and home health care program that varies with the seasons: Spring services are home centered, consisting of in-home visits for administration of medication, cleanings, and other assistance; winter services are residential with elders placed in local institutional care facilities (American Indian Nurses Association, 1978). This plan allows maximum physical protection during time periods when transportation of health personnel is hindered and minimizes psychological distress because elders realize that they will return home soon.

The Nevada program bears testimony that the sense of family roles among elders remains strong. Research on perceived and actual status (Manson and Pambrun, 1979) and perceived filial responsibility (Barber, Cook, and Ackerman, 1980) are mixed and inconclusive. Irrespective, the sense of family responsibility appears as a lifestyle feature that remains crucial in health care plans. Red Horse (1980) identifies this sense of family as a particular aspect of ego integrity characteristic of life span development in American Indian extended family systems. Curley (1978) captures this as a process of role transition for a Navajo elder. This need of continuing family roles was also corroborated by the NICOA Study (1981). It appears sufficient to say that regardless of functional dependence or independence, family re-entry appears as a critical feature of any comprehensive care strategy for American Indian and Alaskan Native elders. The sense of family introduces awesome challenges for the Model. Existing health and social services offered to American Indian and Alaskan Native elders have not been supportive of indigenous family philosophies. There are some compelling reasons for this lack of responsiveness.

Tribal site, natural resources, and remoteness of reservations serve as barometers of fiscal capacity and opportunity to develop viable strategies. Elders from isolated reservations are especially vulnerable to removal from family and community against their choice. Moreover, existing regulations guiding services to elders incorporate service barriers to remote reservations. A particular point of stress, for example, is federal regualtions which set minimum population requirements for tribes to qualify for aging funds. Unless requirements are relaxed, equal opportunity will remain an empty promise simply because of variations in the elderly populations among tribes. While these differential statuses of tribes are overlooked in the Model they are in the forefront among concerns of American Indian and Alaskan Native key informants. Further, allocation formulas based on population tend to favor non-Indian over Indian Communities.

Organizational Strategies

Organizational strategies of the Model address two basic questions: should services be centralized or decentralized, and will resources be derived from the public or private sector? Decentralization through local authority is emphasized. Local Area Agencies on Aging will coordinate assessment, referral, and advocacy for senior adults (60-75) and provide full-floor services for the elder group (75+) with all previously defined responsibilities of outreach, evaluation, and case management. Local Area Agencies on Aging would become a complete aging resource for training and service coordination. Fiscal distribution would be through direct grants to state following the two-tiered service system, i.e., funds for senior adults (60-75) would channel through the general system of adult services, and funds for the elderhood group (75+) would channel through the Older Americans Act with subsequent distribution following State plans. The Administration on Aging would assume a role as national resource to consult on policy and technical assistance needs.

The Model advocates a dismantling of institutional superstructure and a re-empowerment of in-place service groups closest to the aging constituency, i.e., community-based mediating structures identified as family, neighborhood groups, voluntary associations, religious groups and ethnic groups. Following earlier discussion, the conceptual scheme of decentralization and re-empowerment advanced by the Model are in many respects compatible with the needs and aspirations of American Indian and Alaskan Native elders.

Problems identified with the leviathan of public institutions are mirrored in concerns among Indian communities. Table Three identifies selected issues raised by American Indian and Alaskan Native key informants regarding program and organizational strategies. Issues of coordination, compliance, and transfer of technology to tribes are prominent in the listing. Collectively these capture a ubiquitous sense of rising expectations. Tribes routinely have been assured tribal sovereignty and self-determination through policy statements. These aspirations derive from the unique historical relationship emanating through treaties

Table Three

PROGRAM AND ORGANIZATIONAL STRATEGY ISSUES IDENTIFIED BY AMERICAN INDIAN AND ALASKAN NATIVE KEY INFORMANTS

Establish Indian Aging Desks in the Administration on Aging, Bureau of Indian Affairs, and Indian Health Service

Establish an Indian Ombudsman in Health Care

Eliminate Barriers to Coordination

Develop a Single Set of Eligibility Criteria to Coordinate Federal Programs

Establish the National Indian Council on Aging as National, Contractor, Monitor, and Coordinator

Increase Funds for Transportation, Titled Programs, and Training

Allocate 100 Percent Nutrition Funds from Title VI

Revise Food Program Eligibility

Comply with Earlier Findings in Needs Assessment

Recognize Special Legal Relationship between Tribes and Federal Government

Existing Federal Programs Often Not Consistent with Federal Tribal Relationships

Responsibility of Tribes in Social Services Ignored by Administration on Aging

Redefine Eligibility Standards to Fit Tribal Definitions of Need and Needy

Need Complaince for Aging Services by the Bureau of Indian Affairs and Indian Health Service

Revise Fiscal Channels to Establish Direct Funding of Tribes between tribes and the Federal government. Tribes recognize that this relationship has been contaminated through public programs that route resources and regulations through states and result in a maze of bureaucratic barriers to service delivery much to the agony of American Indian and Alaskan Native elders.

Coordination to improve the quality of care emerges as a problem in three major service networks: (1) Federal programs designed to serve the aging population in general, (2) State programs designed to serve the aging population in general, and (3) programs mandated to serve Indian populations only. American Indian and Alaskan Native elders are, of course, entitled to any service provided through Federal Acts whether this be direct or indirect. Results: an array of programs lacking in coordination. While many programs have mandated coordination, there is no way to assure that it will occur. Indeed, mandates requiring coordination in one Federal Law are often contradicted by mandates in related Federal Laws. In this sense, legal institutional barriers actually hinder coordination of programs to elders (NICOA, 1981).

Lack of coordination is evident also at State levels. A survey of mental health programs in Oregon uncovered considerable overlap of responsibilities among agencies with a noted absence of coordination in actual delivery of services (Manson, 1980). Coordination issues also impact intake systems. This is patentlt evident in programs mandated to serve only American Indian populations. An array of eligibility criteria emerge as a result of differential definitions of Indian Status (NICOA, 1981; Bell, Kasschau, and Zellman, 1976).

Compliance reflects the lack of follow-through and response to stated needs among American Indian and Alaskan Native elders. Their relative deprivation is not a new discovery, but a nagging and long-term concern. An early work suggested that Indian elders are ". . . the most deprived identifiable group of American citizens" (Benedict, 1971 p. 51). The 1971 White House Conference on Aging compiled 29 specific recommendations regarding Indian elderly. These identified needs around extreme deprivation in income, housing, nutrition, transportation, and health. The major themes guiding these early recommendations mirror the aggregate concerns of the American Indian and Alaskan Native key informants employed by the current work. Nevertheless, investigators have found no evidence that the 1971 recommendations have been acted upon (Human Resources Corporation, 1978; Manson and Pambrun, 1979), with the single exception of the recommendation for direct federal funding to tribes for the provision of aging services. This recommendation was addressed through the passage in 1978 of Title VI of the Older Americans Act, "Grant for Indian Tribes", which was implemented in 1980.

American Indian and Alaskan Native elders and tribal organizations are quite patient, but both groups recognize that coordination and compliance issues appear insoluble because key actors around those issues are beyond grass roots control. Thus, elders and tribes alike endorse decentralization, but differ from the Model in a major respect: they call for a transfer of technology through direct funding of tribal organizations by the Federal Government. This is not as dramatic as it sounds since title VI of the Older Americans Act provides for direct funding (NICOA, 1981). Direct funding, moreover, appears in accord with tribal sovereignty and self-determination and would by-pass State Area Agencies on Aging. American Indian and Alaskan Native priorities would not be subordinated to other state agenda.

Direct funding to tribes is not simply an issue of money, but an issue of capacity-building. Several State Units on Aging, for example, allocate per capita funds for Indian elders in excess of their proportional population. An analysis of the priorities around the use of such funds, however, indicate differences between State and tribal strategies: States are prone to feed funds back into in-place public institutions while tribal organizations set a priority on capacity building through training of indigenous personnel (NICOA, 1981). Thus, following the Model, tribes see direct funding as a mechanism to facilitate "natural systems" of family, neighborhoods, and ethnic groups.

Summary Discussion

This paper has examined issues pertinent to the "Future Directions in Aging Policy: A Human Service Model." The discussion has focused upon the concerns and life circumstances of American Indian and Alaskan Native elders. While the Model sets forth important and compelling principles, several of its assumptions were challenged. Primary among these were assumptions regarding the aging process, population trends, and availability of services through existing institutional networks. These presumptions could create institutional barriers to services in the absence of appropriate tools to culturally match assessment, evaluation, and case management to the needs of American Indian and Alaskan Native elders.

The discussion has by no means been exhaustive. The integration of available literature with identified concerns of American Indian and Alaskan Native key informants highlight several areas that impact research, education, and training. Among these are: (1) the need for an adequate data base that captures a representative picture of elders and of the numerous tribes and Alaskan Native villages, (2) the need for cultural inquiry of the aging process so that primary prevention strategies can be organized according to life situations and chronic diseases confronting American Indian and Alaskan Native elders, and (3) the need to develop and appraise culturally-matched services through the launching of community-based demonstration services.

Finally, a massive program of training and technical assistance should be developed to facilitate a transfer of technology. A direct funding strategy provides a logical avenue through which the Model can adapt to tribal and village complexity and honor Federal commitments to tribal sovereignty and self-determination. Given the startling differences of needs and priorities between tribal groups and the general population specific "set aside" funds appear necessary to assure that first Americans will benefit from "first rights."

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Footnotes

[1] Hereafter referred to as the Model.

[2] All key informant tables were derived from formal resolutions passed by the General Assembly at the National Indian Council on Aging Conference, Fall, 1980, Albuquerque, New Mexico. The resolutions are published in the final report of this conference, May the Circle Be Unbroken: A New Decade, Albuquerque, New Mexico: National Indian Council on Aging, 1981.

UPADATE OF CURRENT STATUS OF AND FUTURE DIRECTIONS FOR ETHNIC MINORITY ELDERLY GROUPS: PACIFIC/ASIANS

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As we anticipate the outcomes of the White House Conference on Aging (WHCOA), we look toward building on the achievements of the past 10 years. It was at the last WHCOA--not quite 10 years ago--that the Asian/Pacific Islanders discovered that they were excluded from the special concerns sessions for minority groups. Regardless of the reasons for this oversight, the Asian Americans did succeed in having their Special Concerns Session. What is important is that 1971 marks the year that the Asian/Pacific elderly became visible--when it was recognized that they, too, had problems and in many respects, problems and needs even more intense and complex than those of the general elderly population, e.g,. that their suicide rates were three times higher than the national average.

Since then, progress has been made primarily in research and advocacy efforts--such as P/AERP;[1] the inclusion of Chinese, Guamanian, Filipino, and Japanese groups in the San Diego State University cross-cultural study; as well as the more recently-funded P/ARCA.[2] Service programs to serve specific Pacific/Asian populations have also emerged, e.g., the Chinatown and Koreisha nutrition projects in Los Angeles to serve the Chinese and Japanese elderly, respectively; UPAC[3] "Home Helps" in San Diego, and the On Lok Center in San Francisco. Further, the 1981 White House Conference has provided avenues for input through mini-conferences for the major ethnic groups and the Pacific jurisdictions. It has also structured the Conference so that all issue committees will address minority concerns -- rather than, as in 1971, segregating minorities into special concerns sessions.

The 1970s saw the expansion of services to the elderly. However, the decade of the 1980s does not portend as well for minority elders who have just begun to receive some of the benefits of the social services system. The new Administration, in its proposed massive cuts in human services in the name of "economic recovery" makes the Nixon Administration's "benign neglect" policy look meek. The consequence of social services being on the "hit list" is a "divide and conquer" syndrome with all sectors fighting each other for the biggest piece of a shrinking pie, rather than working together for a bigger pie. I hope that we will not be co-opted into this stratagem.

Notwithstanding the current direction of the new Administration, where are we in terms of minority aging, and, more specifically, Pacific/Asian aging? The current status of minority aging, although improved during the past decade, is still highly fragmented and inconclusive. This Codification Project is an effort to provide stronger direction in this area. Although it will assist us, codification can only be possible if we have data to codify. The project to date has compiled the extant literature on minority aging. Of these, approximately 21.5 percent deal with Pacific Asians. And, unfortunately, most of these are literature reviews or overviews, profiles based on census data and needs assessments of individual ethnic communities, or descriptions of services to various Pacific/Asian groups. A comprehensive and representative national data base, other than the 1970 Census data (which have not accurately profiled our population of elders), is grossly lacking. Improvements are forthcoming in the 1980 Census, but those data will not be available soon.

Those of us committed to minority elders must take an active role in developing recommendations for the WHCOA as well as for the Older Americans Act, which will be reviewed by Congress this year. We have been asked to focus on the options for a future aging policy as proposed by the Congressional Subcommittee on Human Services. With this as a framework, let me provide some background on the Congressional Subcommittee's proposal.

The Congressional Proposal for a Future Aging Policy

In light of the National mood for decreased government spending and efforts to provide better services at no additional cost, the Congressional Subcommittee on Human Services proposed its policy on aging in terms of seven options for a "Human Service Model." These options were predicated on giving first rights to those who are presumed to be most functionally dependent, i.e., elders 75 years and older. Based on this premise, it proceeded to place priority on age-specific, long-term care and comprehensive services to those aged 75 and older. Those under 75 years of age are to be limited to assessment, referral, and advocacy services, since they are to use the existing age-integrated adult services system. Within this context, and somewhat contrarily, emphasis is to be placed on prevention rather than treatment--resources for which are not identified. Finally, in terms of implementation of this Human Service Model, the Subcommittee proposed that program and policy decision-making be decentralized and that private sector agencies and natural support groups be the primary deliverers of services.

In this light, I reviewed once again the studies on Pacific/Asian elders. Unfortunately, although we do have research on Pacific/Asian elders, these data were not adequate in assessing the issues proposed by the Subcommittee. The most critical option proposed is that of defining the target group for services--this undergirds all other options. The major question for those of us concerned about the well-being of Pacific/Asian elders is, "What will be the impact of an aging policy based on providing comprehensive services only to those 75 years and older?"

To adequately answer this question we would need accurate age-specific data on the needs of each of our Pacific/Asian groups. These are, in terms of population size from largest to smallest: Japanese, Chinese, Filipino, Hawaiian, Korean, Guamanian, Samoan, other Pacific Islanders, as well as the newer immigrants of Southeast Asian ancestry. We would need to assess their health and economic status, supports, and use of multiple services and benefits. The little research and data we do have only partially address this issue.

-Unique characteristics of Pacific/Asian elderly

Before citing these data, or the lack thereof, in their relation to the potential impact of the seven proposed options, several basic attributes of Pacific Asian elderly must be carefully considered:

1. As an ethnic minority group, the Pacific/Asian elderly, aged 65 and older, number approximately 101,590. Although this comprises .5 percent of the total U.S. population in this age category, the growth rate of the Chinese, Japanese and Filipino elders was 3 to 5 times higher than the rate of their white counterparts during the period 1960-1970.

It is expected therefore that the 1980 census, which attempted to correct the undercounting of the 1970 census, will show a larger proportion of Pacific/Asian elderly to the total population. Another factor supporting this expectation is the increasing influx of immigrants from Pacific and Asia. For example, the increase between 1965 and 1973 for Koreans was 959 percent and for Filipinos, 883 percent. Among these would be a large number of elderly since the tendency of these groups has been to immigrate as families which include older parents and relatives.

2. As a minority group, the Pacific/Asian includes the disparate Oceanic cultures of Micronesia and Polynesia as well as the culturally distinct groups from Asia. In addition, as with all other minority groups, the diverse subgroups within each major ethnic group defy simplification of any sort. Immigration patterns, socio-economic status, generational differences, and a host of other elements contribute to the heterogeneity of this minority group.

Another factor which must be understood, particularly in reference to the Pacific Islanders, is the need to differentiate between those who have migrated to the U.S. mainland and Hawaii, and those that reside in U.S. jurisdictions. Although confronted with rapid changes associated with advancing technology and "Americanization," these jurisdictions perceive their needs as different from those who have emigrated.[4]

3. The Pacific/Asian population is clearly clustered in certain geographic regions. Estimates in 1975 indicate that one-third

reside in California; one-fourth in Hawaii. Other concentrations occur in the larger cities. The 1970 Census indicated that 90 percent of Asian American elderly lived in urban areas, compared to the national average of 73 percent. They reside in cities such as Honolulu, San Francisco, Los Angeles, New York, and Chicago, for example. Although largely urban, there are nonetheless strong regional differences. The services for Hawaii's Pacific/Asian elderly, for example, are ethnic-integrated while those on the West Coast are ethnic-specific. For the Pacific jursidictions, the delivery modalities will also be necessarily different from those elsewhere.

4. The majority of Chinese, Japanese, and Filipino are foreign born with the highest proportion (82 percent) of foreign-born found among the Filipinos. Recent immigrants will add to this number, creating a continuing mixture of foreign and native-born.

5. In terms of health levels, the study by Cuellar and Weeks (1980) on equity in public benefits delivery to minority elders in San Diego may shed some light. Included in the sample were Filipinos, Samoans, Guamanians, Japanese, Chinese, and Korean elders. Although age-specific analyses have not been conducted, data are available for further analyses by age. What the data indicate, however, is the fact that all these Pacific/Asian groups, except for the Filipino and Japanese respondents, rated their

health as poor or very poor more frequently than their non-minority counterparts. Further, the severity of needs was greater than non-minority elders in a number of different areas other than health needs, such as income, housing, transportation, and, more importantly, information on services and benefits available to them. As found here and in other studies such as the Valle cross-cultural study, the Gutman (1980) study of equity in benefits for minorities in Washington, D.C., and the P/AERP survey of service providers, Pacific/Asians form a highly heterogeneous group, and do have needs, which, unfortunately, are not served by the formal service system.

-The underlying issue: should comprehensive services go to the "old old" only?

To answer more cogently the provision of comprehensive services to only those elders 75 years and older, we need only look to data on the age distribution of chronic diseases which usually leave the individual incapacitated and in need of multiple services. These data are not available by ethnic group and by age breakdowns; however, some data were obtained from Hawaii, where 76 percent of its elderly population is Pacific/Asian.

In 1979-80, the Honolulu Arthritis Center admitted 284 cases. The age distribution of these admissions ranged the spectrum from under 16 years to over 75. Only 4 percent were over 75, however, with the greatest proportion (45 percent) being between the ages of 45 and 64 years.

Further, statewide data from Hawaii, ("Hawaii's Vulnerable Elderly--Needs and Needed Resources," 1979), indicates that 76 percent of the elderly 75+ had one or more chronic conditions compared to 71 percent of those in the age group 65-74. When translated into actual numbers, however, these percentages reflect 13,800 for the age group 75+ and 27,000 for the age group 65-74. The question, then, is "which age grouping has the greatest number in greatest need?" Furthermore, although the average life expectancy rate is expected to increase dramatically in the next 20 years, in Hawaii, where life expectancy is ranked the highest in the nation, it is 73.6 years--two years lower than the age criterion of 75 used by the Human Service Model.

These data, then, although partial, point to the need to reassess the proposal for giving first rights to those 75 years and older. Although the Subcommittee does incidate that "anyone slipping into functional dependence, even at an earlier age," would be served, using age 75 as the initial criterion, rather than functional dependence per se, would, once again, overlook most minority groups whose life expectancies are, on the average, shorter than their non-minority counterparts and who are less likely to be visible to the formal system of services. What would be more equitable for Pacific/Asian elders, and, minority elders in general, would be a policy based on functional dependence regardless of chronological age. Data available provide evidence that chronic diseases and need for support services strike at varying ages; and, although their frequency increases with age, those under 75, particularly of minority groups, are also in need of comprehensive services.

If we are to focus on functional need, we must begin to develop more focused research in the coming decade. At the forefront of our efforts should be the development of an equitable definition of "functional dependence," including not only physical limitations but availability of resources as well. We must obtain accurate national data regarding chronic conditions and their severity, economic and social resources, and physical and emotional health status of varying age and ethnic cohorts on a regular basis.

The Proposed Congressional Options -- How do we Assess Them?

The options proposed by the Subcommittee are premature with the data at hand, and proceeding to implement such a proposal would be hazardous particularly to the minority elderly. In order to address these issues we need--and do not have--data on the following concerns:

1. On target groups and age-specific services: we need to know age-specific mortality and morbidity rates as well as the number and types of chronic conditions and limitations in activity with age for the various Pacific/Asian subgroups. We also need data on

differential rates not only by age but also by immigration wave and geographic locales, as well as more information on the multiple needs of these groups and what proportion are, in fact, using needed services.

The discrepancy between need and service utilization has been corroborated by various studies in California and Washington, D.C. (Colen and Soto, 1979; Cuellar and Weeks, 1980; Guttman, 1980; Ishizuka, 1976). However, we need more definitive information on the use of services in an age-integrated system versus an age-segregated one. For example, Colen and Soto (1979) found that programs exclusively for seniors or in which major components were earmarked for seniors were more likely to be successful in serving minority older persons than those which were age-integrated. We need to have these results corroborated on a larger scale and in different locales across the country.

2. On prevention vs. treatment: The proposed emphasis on prevention vs. treatment seems to contradict the Human Service Model's other emphasis on the functionally dependent population over 75. Nonetheless prevention, as a cornerstone of our aging policy, is critically needed, particularly because of its long term effect on reducing frailty at later ages.

To adequately meet the needs of our Pacific/Asian elders, it must take into account the variations in life styles, immigration experiences, cultural values and beliefs, and the support systems of our elders in terms of what does and does not contribute to their health and well-being. We need ethnic, age, and generation-specific data on stress factors and nutritional patterns as well as longitudinal data to assess their effects over time, particularly as it affects the aging process.

Of import in prevention are the behaviors and attitudes toward nutrition, health care, self-care, and early detection. The changing of unhealthful behaviors and conditions are possible only if these elders are understood in this context. If prevention is to be effective, then, more effort must be placed on obtaining ethnic-specific longitudinal data on factors related to well-being, and by delineating behaviors and traditions which can be used to maintain and promote health and well-being in old age.

3. On type of services: The type of services which should be addressed in the future Human Service Model, should concern Pacific/Asian elders. At present there are no data on utilization of either acute or long-term care facilities nor on other support services used by those who are frail and, if used, whether services designed for specific ethnic groups are used more frequently than those that are not. We need to examine the modes of coping with frailty by the formal system as well as by the informal family and neighborhood networks.

One of the problems surfacing more visibly of late has to do with the care of frail elderly family members. An unpublished study (Endo and Yoshida, 1968) of adult children of residents of Keiro Nursing Home, the only such facility for Japanese in Los Angeles, indicated the stresses of confronting the fact that one's parent had to be institutionalized and could not be cared for in one's own home. It is apparent, then, that we need to know more about not only the elders' needs for long term care but the needs of their support networks as well.

4. On scope of services: In terms of the scope of services, we must first assess the impact of providing comprehensive services on the elder's independence. Does the provision of such assistance hinder or facilitate the person's independence? Further, if comprehensive services are to be provided for those elders 75 years and older only, we would be neglecting the prevertative aspects of care and serving even less equitably our "young-old" Pacific/Asians, who are having difficulty at present obtaining the multiple services they need. The equity benefits studies in San Diego and Washington, D.C. indicate these multiple needs of our elders, ranging from housing, and transportation to medical care. If these services are not provided when needed, but at a later time when severity of problems negates their benefits, how will our elders fare?

5. On Adminsitration and policymaking: Two other options which should not be overlooked in the Subcommittee's proposal deal with the administration and implementation of the human services system. The Congressional intent and the new Administration's inclinations all point to the decentralization of policymaking and service provision.

Historically, the 1960s saw the proliferation of federal categorical programs with hundreds of millions of dollars spent on social welfare and allied programs. The consequence of these federal initiatives was to increase the service delivery activities in the public sector and to blur the private sector role in providing services, ultimately confusing the recipients of services. The 1970s saw the Administration's attempt to bring order through block grants and through revenue sharing programs as well as through efforts by States to reorganize programs to integrate the human services. However, these attempts have not been totally successful, perhaps due to the failure of those at the policy-making levels to develop a clear vision of what should comprise the human service system and to evaluate the efficacy of the existing service system modalities. The same situation seems to be facing us today at a time when resources are even less available for human services. Although philosophically, a decentralized system seems most feasible in being most responsive to minority communities, we have yet to assess the efficacy of direct funding of ethnic-specific demonstration projects versus block grants to local communities.

Here we can learn from our Pacific jurisdiction colleagues who have been more successful in maintaining the cultural influence in their services. Perhaps because of the greater homogeneity of the communities within their jurisdictions, they have been able to serve well their elders under the current system through requesting waivers so as to maintain intact their cultural traditions and extended-family networks. However, because they do receive categorical grants from the Administration on Aging, certain regulations have prevented them from adequately servicing the unique needs of their elders.[4]

6. On roles of private and public sectors: The final option proposed by the Subcommittee is that of utilizing and developing private sector agencies and natural support groups, rather than the public sector, to deliver services. Although we have data to indicate that ethnic-based community agencies have been more successful in attracting ethnic elders to their programs, we have no data on whether these programs have been more cost-effective than public agencies in meeting elders' needs and in preventing dysfunction and premature institutionalization. We are beginning to obtain data, for example. On Lok had begun collecting a comprehensive file on all their clients, but we need more conclusive and comparable data from both private and public agencies.

Yes, we do need to look at natural support systems. For elderly

Asians and Pacific Islanders, the use of formal agencies outside the family and neighborhood network is foreign. Whether it is the family or the ethnic community for Asians, the matai system for Samoans, or the ohana system for Hawaiians, these networks are significant supports to the older minority communities. However, we need to explore further the extent to which these social structures are used by our elderly to alleviate problems. We need to also look at the effect of current policies on these systems, for example, the SSI and Medicare regulations discouraging family care of the disabled, as well as the tolerance level of these systems in providing for frail elders, i.e., at what point they break down, and what supports--fiscal and otherwise--can buttress this system. Additionally, we have no data on the extent to which the natural support systems exist for our ethnic elders nor on the degree to which they have been included in policy-making and service provision. We also need to know the critical components for effective service to our Pacific/Asian elders regardless of who provides the service.

The Missing Linkage

The one critical component which I find missing from the Congressional Subcommittee's model for human services is the human element, i.e., those critical links between the client and the service. The problem for the Asian/Pacific elderly--or, for the elderly in general--is not the lack of services. Although varying by locale our elderly can currently obtain nutritious meals, transportation, housing assistance, in-home services, nursing and medical care, legal services, counseling, recreation, education, as well as employment. The problem is that the Asian/Pacific elders are underutilizing these services. We even know the factors involved: lack of knowledge of services, inaccessibility to services, stigma of receiving services, lack of bilingual/bicultural staff. P/AERP's findings (September, 1977) on critical factors in service delivery was too general to shed any new light on the matter. It highlighted what we already knew--that the Asian/Pacific elderly underutilize services because of the lack of bilingual/bicultural staff and services, because of the lack of cultural sensitivity, and because of the lack of outreach.

The critical question before us is not whether Asian and Pacific American elders have needs, but rather, how should programs be designed so as to enable them to use the services they need. Some answers can be gained from the technical monographs developed by San Diego State University's cross-cultural study of minority elders in San Diego. Karen Ishizuka's (1978) monograph on the Japanese elderly provides the kind of in-depth analyses and insight which can move us beyond the usual complaints of not having sufficient data. Although limited by a small sample size (N=60) which was skewed toward those better off financially (she states that some of the potential respondents refused to participate because they were not financially able enough) and otherwise (53 percent of the sample, for example, expressed no needs), she provides some insight into the problem of underutilization. She stresses, for example, the importance of pride in self and in one's Japanese identity in understanding why these Japanese elderly would not publicize their problems to others outside their family network nor would accept services from outside agencies unless, of course, one were "destitute."

Her "psycho-social price" hypothesis is quite interesting and bears futher examination, particularly by service providers who are constantly trying to obtain more services for the Pacific/Asian elderly. If she is correct, Japenese elderly will not utilize services unless they felt they had no other recourse and were, in fact, destitute, or unless the services were seen not as a "hand-out" but, in fact, available to anyone regardless of financial situation, e.g., social security or a plumber's services which one pays for. Ishizuka's analyses are much needed in the field and should provide the impetus for others working directly with the Asian/Pacific elderly to develop such paradigms to explain behaviors and attitudes.

After examining the various Asian/Pacific elderly monographs of the San Diego State University study, which included the Japanese, Chinese, Filipino, Guamanian, and Samoan elderly, I have found more similarities than dissimilarities in their attitudes toward utilizing services. I would thus posit that all ethnic groups have the same needs for income, health, housing, and transportation. The difference lies in the area of service delivery modes, i.e., informing elderly of services, explaining services to them so that they will accept and use services they need, and getting them to modify services according to their preferences.

Thus, on the one hand, in all studies conducted on needs and service utilization, what has been found consistently is that the Pacific/Asian elderly underutilize services even when needs exist. More importantly, not only is information on services and benefits lacking, but even when services are known, they are reluctant to use services of the formal system. On the other hand, experiences of such ethnic-specific programs such as On Lok, Koreisha and Kimochi nutrition programs, and UPAC's programs for Pacific/Asians in San Diego have demonstrated high participation by Pacific/Asian elders. A recent study of various elderly programs in California examined a number of factors important to success in service delivery to elderly Asian Americans (Colen and Soto, 1979). Of the 24 items identified, 13 (over 50 percent) concerned outreach and information dissemination through ethnic media and individuals. Other components that were critical included having staff who were sensitive to the needs of Asian clients as well as the site location within the community.

Further, examination of successful ethnic programs indicate that Asian/Pacific elderly do use services when they are in need, but there are several common denominators which must be present:

a) they are located in the neighborhood, and are easily accessible to them;

b) they have an informal and personalized climate;

c) they have staff who are client-oriented, and who assist elders to get all the services needed;

d) they have bilingual and/or indigenous outreach workers who are concerned about the people and the community they serve, and are identified by the elderly as "knowledgeable friends" who can help.

The need for bilingual staff becomes more critical for Pacific/Asian elderly. For example, among the Chinese and Japanese elderly 65+, more than 80 percent do not use English as their mother tongue. As Brown, et al. (1973) found, the success of their mental health services and outreach efforts in the L.A. Chinatown area was due to their bilingual, culturally-sensitive workers who lived in the catchment area. Similar findings were reported by Kent and Hirsch (1971) in their use of indigenous ethnic interviewers to obtain data on the needs of urban, low-income minority aged, as well as by Suzuki's (1978) "Culture-Specific Mediators" in San Francisco's Chinatown.

Conclusion

In short, the Pacific/Asian community is beset with a myriad of questions with very little, fragmented data to produce conclusive answers regarding the ultimate issue of a future service system that will deal equitably with our elders. What we do know is that our Pacific/Asian elders are more likely to have problems in meeting basic needs than their non-minority counterparts; that they are heterogeneous, varying by ethnic group as well as within groups; e.g., by immigration wave and experiences; and that, although they have needs, they are less likely to know of services and to use them.

The policy shift posited by the Subcommittee on Human Services assumes that the Aging Network has done so well in mainstreaming our elders that they will be able to obtain all services they need in the adult service system. Although fragmentary, our data just do not bear this out. Our Pacific/Asian elders have difficulty accessing needed services even in the age-specific system. The aging policy for the future should place greater emphasis on linking needy elders to the services they need. At the same time, we should not lose sight of advocating on behalf of all elders to improve their quality of life, including such preventive activities as nutrition, socialization, transportation, etc. If this is to be accomplished, the human service system must: 1) be based on more accurate and comprehensive data on all elderly, including our Pacific/Asian subpopulations, with longitudinal data on factors related to health and well-being in the later years, and 2) sensitize service deliverers to cultural variations in implementing an equitable and effective service delivery system. In conclusion, what the data available to date consistently tell us is that our Pacific/Asian elders have multiple needs, with the most critical being access to services and benefits as well as the need for service deliverers to be sensitive to their cultural and language needs. If the focus of aging policy will be on the 75 and older population, it will neglect the majority of our elders in need, who have only recently adjusted to using services heretofore available and accessible to all elders. Our deliberations and recommendations for a future aging policy must go beyond the Congressional parameters -- based primarily on fiscal considerations-- if it is to be truly equitable and humane.

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FOOTNOTES

[1] Pacific/Asian Elderly Research Project

[2] Pacific/Asian Resource Center on Aging

[3] Union of Pan Asian Communities

[4] The uniqueness of the Pacific jurisdictions (American Samoa, Guam, Commonwealth of the Northern Mariana Islands, and Trust Territory of the Pacific Islands) is comprehensively described in the four monographs written by Leonard Mason. These are listed in the Minority Aging Codification Project bibliographies.

7

ELDERLY PACIFIC ASIANS: EMERGING RESEARCH ISSUES

Sylvia Yuen Schwitters, Ph.D.

There are three caveats the reader should keep in mind in this discussion of elderly Pacific Asians. The first pertains to the inherent diversity of the population. Elderly Pacific/Asians include native-American Hawaiians and recent Indo-Chinese refugees, first-generation Issei from Japan and third-generation American born Sansei, Samoans sharing the same household with a myriad of extended family members and single Filipino men living alone in rooming houses, college educated Chinese and illiterate Chinese. Among this broad span of people are the commonly acknowledged variations in language, values, traditions, and history (Pacific/Asian Elderly Research Project, 1978b) and the less frequently cited differences in life expectancy and health (Yuen Schwitters & Ashdown, 1981; Yuen Schwitters and Tomita, 1981). Thus, although individuals of Asian and Pacific Islander backgrounds frequently are lumped into a single category, generalizations regarding the group as a whole are often misleading, for what may be accurate for one subset may not be so for another.

The fact that the Pacific/Asian population is dynamic and constantly changing is the second caveat of which the reader should be aware. Whereas the heterogeneity of the population refers primarily to within group differences (that is, among the various ethnicities within the Pacific/Asian group), the dynamism of the population results largely from cohort differences over time. Changes in migration patterns, reproduction rates, and acculturation contribute to an ever shifting

Pacific/Asian scene. For example, in 1970 the Japanese comprised the largest ethnic group within the Asian and Pacific Islander population in the United States. In 1980, however, primarily because of different levels of immigration, the Chinese counted by census grew from 435,062 to 806,027 individuals, a percentage increase of 85.3%, the Filipinos increased from 343,060 to 774,640 individuals for an increase of 125.8%, while the Japanese experienced the slowest growth--from 591,290 to 700,747 individuals and an increase of 18.5% (Bureau of the Census, 1981). Of particular interest is the fifth largest group by the 1980 census count, the Koreans (fourth were the Asian Indians with 361,544 individuals), who quadrupled their number by a phenomenal 412.8% beween 1970 and 1980 (from 69,130 to 354,529 individuals). Besides the uneven growth among the different ethnic groups, other factors, such as the more balanced sex ratio among younger generations of Asians and the regional re-distribution of the Pacific/Asian population (e.g., 13.4% were located in the South in 1980 compared to 7.4% in 1970), make it imperative that the statements and perceptions regarding this minority group are continually reshaped and updated.

The third caveat relates to the body of research knowledge in the area. The present state of the literature has been described as descriptive and impressionistic, limited to small samples and specific areas, and with national, cross-national, and cross-cultural studies virtually non-existent (Pacific/Asian Elderly Research Project, 1978c). Furthermore, the majority of the materials consists of unpublished papers, conference proceedings, government documents, and project reports, rather than empirical research published in refereed journals. Although criticism regarding the quality of the literature is justified, they should be coupled with the acknowledgment that research on Pacific/Asian elders is in its infancy. The recognition of aged minorities as groups meriting special concern is a recent phenomenon, gaining national prominence just immediately preceding and during the 1971 White House Conference on Aging (Jackson, 1980). Polemics and politics were used to cast elderly minorities, including Pacific/Asians, as categorically unique individuals with problems not addressed by programs designed by and for majority people. These efforts resulted in greater interest in ethnic minorities and the creation of national organizations which gave greater visibility to the concerns of their elderly constituents. The National Pacific/Asian Resource Center on Aging (NP/ARCA) was created in 1979, and along with the National Caucus and Center on Black Aged, the National Indian Council on Aging, and the Associacion Nacional Pro Personas Mayores, its activities were primarily funded by the Administration on Aging.

Table 1 presents data from four general reference services--Dissertation Abstracts, Medline, Psychological Abstracts, and Social Science Index--covering both the biological and psychosocial literature on elderly Pacific/Asians from 1950 through 1979. The number of citations per year indicate that published reports on this group of ethnic minorities commenced in the mid-sixties for the biological sciences and in the seventies for the psychosocial sciences. As shown in Table 1, the year in which the median number of publications appeared was in the mid-1970s for each of the four service indices. It is significant that prior to the early sixties, none of the reference services listed a single entry on Pacific/Asian aged.

The number and percent of documents relating to each of the four major minority groups (Blacks, Native Americans, Hispanic Americans, and Pacific/Asians) by the four general reference services are presented in Table 2. In keeping with the data depicted in Table 1, the total number of citations in the 1970s was from four (Medline) to fifty-two (Psychological Abstracts) times greater than was recorded for the previous two decades. In three of the reference services (Dissertation Abstracts, Psychological Abstracts, and Social Science Index) a majority of the entries focused on Blacks (52.6% - 61.3%), followed by a considerably smaller pool of entries on Pacific/Asians (17.3% - 21.1%), Hispanic Americans (5.8% - 16.1%), and Native Americans (0% - 5.3%). Except for the reversal of the last two ethnic groups, the order for the number of citations in Medline resembled the other services: Blacks (44.7%); Pacific/Asians (42.1%); Native Americans (11.0%), and Hispanic Americans (2.3%). Both the greater number of entries in Medline and its differential services, can be explained by Medline's international scope. Rather than a primarily national focus, Medline reports on health related articles in journals throughout the world, a number of which emanate from Asiatic countries.

Given the recent interest in aged Pacific/Asians, the paucity and unevenness in the quality of the knowledge base in the field is

Table 1

Summary of Aged Minority Citations in General Reference Services, 1950-1979

	Year																														
	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	Total
Dissertation Abstracts														1											1	3*	1				6
Medline															1	18	32	28	42	42	42	34	44	33*	60	44	43	50	40	36	589
Psychological Abstracts																						2		2	*	3		1			8
Social Science Index																								1		2	4*			1	8
Total														1	1	18	32	28	42	42	42	36	44	36	61	52	48	51	40	37	611

*Median Point

Table 2

Summary of Aged Minority Citations in General Reference Services, 1950-1979

	1950-1959		1960-1969		1970-1979		Total	
	No. of Citations	%	No. of Citations	%	No. of Citations	%	No. of Citations	%
DISSERTATION ABSTRACTS								
Blacks	0		2	66.6	17	60.7	19	61.3
Native Americans	0		0				0	
Hispanic Americans	0		0		5	17.9	5	16.1
Pacific/Asians	0		1	33.3	5	17.9	6	19.4
Other	0		0		1	3.6	1	3.2
Sub-Total	0		3	100.0	28	100.0	31	100.0
MEDLINE								
Blacks	0		119	41.0	533	45.6	652	44.7
Native Americans	0		8	2.8	152	13.0	160	11.0
Hispanic Americans	0		0		33	2.8	33	2.3
Pacific/Asians	0		163	56.2	451	38.6	614	42.1
Other	0		0		0		0	
Sub-Total	0		290	100.0	1169	100.0	1459	100.0
PSYCHOLOGICAL ABSTRACTS								
Blacks	0		0		28	53.8	28	53.8
Native Americans	0		0		1	1.9	1	1.9
Hispanic Americans	0		0		3	5.8	3	5.8
Pacific Asians	0		0		9	17.3	9	17.3
Other	0		0		11	21.2	11	21.2
Sub-Total	0		0		52	100.0	52	100.0
SOCIAL SCIENCE INDEX								
Blacks	0		1	100.0	19	51.4	20	52.6
Native Americans	0		0		2	5.4	2	5.3
Hispanic Americans	0		0		5	13.5	5	13.2
Pacific/Asians	0		0		8	21.6	8	21.1
Other	0		0		3	8.1	3	7.9
Sub-Total	0		1	100.0	37	100.0	38	100.0
TOTAL CITATIONS IN FOUR GENERAL REFERENCE SERVICES	0		294		1286		1580	

not surprising. The expectation that the present literature yield answers to a variety of policy issues based on indisputable evidence is unrealistic. In the years ahead, research on Pacific/Asian elders can, and should, be expected to be conducted with greater rigor, sophistication, and quantification than that present in much of what is currently available.

This is not to say that substantial gains have not been made in the field. There is, for example, a respectable body of information (Cuellar & Weeks, 1980; Colen & Soto, 1979; Federal Council on Aging, 1979; Guttmann, 1980; Pacific/Asian Elderly Research Project, 1978a) now available regarding both the barriers to services and resources that elderly Pacific/Asians confront and the components essential to culturally relevant programs. The barriers include lack of English proficiency, lack of knowledge concerning resources and how to gain access to them, lack of transportation, the location of services outside of minority communities, and cultural values that are at odds with seeking and receiving public benefits. The components of success encompass the presence of bilingual/bicultural workers in multiservice senior centers, based in minority communities, which employ Pacific/Asian elders in the planning process and which have an effective outreach system.

The purpose of this section is to assess the present state of the field and to delineate the areas in which research is most critical. Where are the gaps in research concerning elderly Pacific/Asians which should be addressed? Four crucial areas deserving of attention are identified below.

Need for Inclusionary Research

Although data relating to the entire populace are important, ethnic minorities, particularly American Indians, Hispanic Americans, and Pacific/Asians, have been ignored and treated as non-persons in the information gathering and reports on the old. In virtually all surveys on older people in the United States--among them the Annual Housing Survey by the Department of Housing and Urban Development, the various health surveys by the National Center for Health Statistics, and public opinion polls on and about older people--Pacific/Asians are noticeably absent. When data are not available on selected subgroups of the population, their status, needs, and concerns are not presented in governmental reports (e.g., Federal Council on Aging, 1981; President's Commission on Mental Health: Task Panel on the Elderly & Secretary's Committee on Mental Health and Illness of the Elderly, 1980), textbooks, journal articles, the popular press, and other channnels of communication. The philosophies, ideas, and perceptions of lawmakers, policy formulators, scholars, and the general public are shaped to a substantial degree by the information to which they are exposed. What many fail to realize is that the absence of information is also crucial in the development of attitudes and points of view.

If there is no information regarding Pacific/Asians, the assumption is too often made that they are not different along any dimension from individuals from the majority culture. If there are no reliable data documenting need, it is often concluded that Pacific/

Asians are problem free. The omission of this group of ethnic minorities begins early in most investigations when race/ethnicity is conceptualized during planning and defined in the design of inventories as White and Other, White and Black, or at most, White, Black, and Other. All of these categories cast non-White people together and are insensitive to the heterogeneity among minority group elders. During the data collection stage, Pacific/Asians tend to be excluded and under-counted because special efforts are not expended to locate them and to transcend cultural and language barriers. There is, at present, an appalling lack of national data on Pacific/Asian elders, and although some evidence regarding their specific needs is available from small local investigations, these are generally insufficient to have major impact in shaping public attitudes and on the determination of national policies, programs, and funds.

The National Caucus and Center on Black Aged, the National Indian Council on Aging, and the Asociacion Nacional Pro Personas Mayores each has been funded within the last five years to conduct basic needs assessments on their elderly constituency. While these investigations may be necessary in the short-run because of the absolute dearth of information on these ethnic populations, they do not lead to the most productive long-term resolution of the problem. The inclusion of all minority groups, including elderly Pacific/Asians, in ongoing national assessments offers the better solution. Parallel systems of assessing the needs and status of minority older people are too dependent on the political climate, availability of special funds, and other shifting conditions. Moreover, because they are not conducted on a regular basis, they can never yield as much information nor offer the advantages that ongoing assessments provide--consistency over time, currency of information, timely reporting of results, and comparability of data within and among population subgroups.

A major, positive step in the inclusion of Asians and Pacific Islanders in standard surveys is the 1980 census of the United States population. The Bureau of the Census provides what is probably the most frequently utilized data set in the nation. For many in the aging network, it is the primary and only source of data on specific groups of people. In 1977 the Pacific/Asian Elderly Research Project conducted a survey of seven states to ascertain to what extent data had been gathered on the needs of Pacific/Asian elders in compliance with Administration on Aging regulations. Thirty-nine state agencies from a total of 56 units (69.6%) responded, with less than half (N=15; 38.5%) reporting having any information on the target ethnic group. Thirteen of the 15 state agencies with information (86.7%) indicated their baseline information came only from the 1970 census. Among the 116 area agencies surveyed, 70 responded (60.3%) with 45 (64.3%) having no information and the remainder (N=25; 35.7%) relying totally on census data for their knowledge on the needs of and baseline and service information on Pacific/Asian older people.

Fortunately, the 1980 census will provide more information on race than any previous United States census. In the 1970 census, race was indicated by nine discrete categories, including a write-in option: White; Black; Indian (American); Chinese; Filipino; Japanese; Hawaiian; Korean; and Other (specify). Information on race was obtained through self identification in the 1980 census using fifteen classifications, including a write-in option: White; Black or Negro; Japanese; Chinese; Filipino; Korean; Vietnamese; Indian (American); Asian Indian; Hawaiian; Guamanian; Samoan; Eskimo; Aleut; and Other (specify). When more than a single response was given for race on the 1980 census inventory, the race of the person's mother was coded. If more than one response was provided for the mother, then the first race reported by the respondent was recorded.

In forthcoming publications, data from the 1980 census will be reported separately for the Chinese, Filipino, Japanese, Korean, Asian Indian, Vietnamese, Hawaiian, Samoan, and Guamanian populations (provided each group meets minimal size requirements for particular geographical regions), as well as for the total Asian and Pacific Islander population (i.e., the sum of all of the aforementioned racial groups). The last census asked respondents to report for the first time the ancestry group with which they were identified. The race and ancestry indices should not be confused with one another. The latter refers to the nationality group, lineage, or country in which the respondent's parents or ancestors were born before entry into the United States. In reporting the ancestry data, census publications will utilize 15 single ancestry groups--Dutch, English, French, German, Greek, Hungarian, Irish, Italian, Norwegian, Polish, Portuguese, Russian, Scottish, Swedish, and Ukranian--and six multiple ancestry groups. Because all of these groups have as their reference European countries, individuals focusing on Pacific/Asians will do well to ignore the ancestry data and to concentrate on the group of interest under the race heading. Table 3 presents the availability of statistics and a description of its characteristics for Asian and Pacific Islander people from the 1980 census.

Although the 1980 census is far from perfect (e.g., tabulations on only nine ethnicities, whereas there are more than 18 distinct Pacific/Asian groups, and ethnic minorities, in general, will still be undercounted), it is the first serious effort by a federal body to provide information on Asians and Pacific Islanders in the same manner as is used for people from the majority culture. The census will provide a wealth of data not previously available; however, detailed information on the health, economic, and housing status of elderly Pacific/Asians are still needed. Other governmental and private bodies, such as the Department of Housing and Urban Development, the Social Security Administration, and the National Center for Health Statistics, should follow the lead set forth by the Bureau of the Census. Admittedly, the small number of Pacific/Asians in comparison to the total United States population will require procedures and expenditures beyond present levels if inclusion is indeed to occur--for example, the employment of translated protocols and sophisticated sampling techniques to insure sufficient numbers of respondents for data analyses. However, such actions are long overdue and are a necessary process in the full recognition and equitable treatment of all of this nation's people.

TABLE 3

AVAILABILITY OF STATISTICS ON PACIFIC/ASIANS FROM THE 1980 CENSUS OF POPULATION AND HOUSING[φ]

1980 CENSUS REPORT (Geographic Areas)	CHARACTERISTICS	ASIAN & PACIFIC ISLANDER
PHC80-V, Final Population and Housing Unit Counts†		
United States	Population counts	X
States		
Counties		
County subdivisions		
Incorporated places		
Congressional districts		
PHC80-1, Block Statistics†		
States	Population counts	X
SMSA's		
Counties		
County subdivisions		
Places		
Tracts		
Blocks		
PHC80-2, Census Tracts†††		
SMSA's	Population counts	X[1]
Central cities		
Counties		
Places of 10,000 or more		
Census tracts		
SMSA's*	Age and sex, fertility, household relationship, education, family composition, marital status, nativity, language usage and ability to speak English, residence in 1975, journey to work, disability status, labor force status, industry and occupation, income and poverty status. Structural, equipment, financial and household characteristics of housing units.	X
Counties*		
Places of 10,000 or more*		
Census tracts		

1980 CENSUS REPORT (Geographic Areas)	CHARACTERISTICS	ASIAN & PACIVIC ISLANDER
PHC80-3, Summary Characteristics for Governmental Units+++ States SMSA's Counties County subdivisions Incorporated places	Population counts	X
PC80-1-A, Number of inhabitants+ United States Regions Divisions States SCSA's, SMSA's Urbanized areas Incorporated places Counties County subdivisions	Population counts	--
PC80-1-B, General Population Characteristics+ United States Regions Divisions States SCSA's, SMSA's Urbanized areas Places and towns/townships of 1,000 or more Counties Rural portion of counties	Population counts by sex	X[1]
United States States SCSA's, SMSA's Urbanized areas Places and towns/townships of 50,000 or more Central Cities Places and towns/townships of 10,000 to 50,000 Places and towns/townships of 2,500 to 10,000 Counties	Age and sex, household type and relationship, type of family and marital status	--

1980 CENSUS REPORT (Geographic Areas)	CHARACTERISTICS	ASIAN & PACIFIC ISLANDER
PC80-1-B, General Population Characteristics (Con.)†		
United States Regions States SCSA's*, SMSA's* Urbanized areas* Places and towns/townships of 50,000 or more* Central cities* Places and towns/townships of 10,000 to 50,000* Places and towns/townships of 2,500 to 10,000* Counties*	Age and sex, household type and relationship, type of family and marital status	X[1]
PC80-1-C, General Social and Economic Characteristics††		
United States Regions Divisions States SCSA's, SMSA's Urbanized areas Places and towns/townships of 50,000 or more Places and towns/townships of 2,500 or more Counties	Population counts	X[2]
United States States Counties	Population counts for rural and rural farms	X
United States States	Age and sex, fertility, household relationship, education, family composition; nativity and place of birth, residence in 1975, journey to work, disability status, veteran status, labor force status, class of worker, industry and occupation, income and poverty status	X[2]

1980 CENSUS REPORT (Geographic Areas)	CHARACTERISTICS	ASIAN & PACIFIC ISLANDER
PC80-1-C, General Social and Economic Characteristics (con.)††		
States SMSA's*** Urbanized areas*** Places and towns/townships of 50,000 or more*** Central cities*** Places and towns/townships of 10,000 to 50,000*** Counties*	Age and sex, fertility, household relationship, education, family composition, marital status, nativity and place of birth, residence in 1975, journey to work, disability status, type of group quarters, veteran status, labor force status, class of worker, industry and occupation, income and poverty status	X
Places and towns/townships of 2,500 to 10,000*	Education, residence in 1975, labor force status, industry and occupation, income and poverty status	X
PC80-1-D, Detailed Population Characteristics††		
United States States SMSA's of 250,000 or more****	Cross-tabulations of social and economic characteristics by age sex, etc.	X
States SMSA's of 250,000 or more****	Social and economic characteristics	--
HC80-1-A, General Housing Characteristics†		
States SMSA's Places and towns/townships of 1,000 or more Counties	Summary of general housing characteristics	--
United States Regions States	Occupancy, plumbing financial, and utilization characteristics	X^1

1980 CENSUS REPORT (Geographic Areas)	CHARACTERISTICS	ASIAN & PACIFIC ISLANDER
HC80-1-A, General Housing Characteristics (con.)†		
United States Regions States SMSA's Places and towns/townships of 50,000 or more Places and towns/townships of 10,000 to 50,000* Places and towns/townships of 2,500 to 10,000* Counties	Occupancy, plumbing financial, and utilization characteristics	--
SCSA's SMSA's Urbanized areas Places and towns/townships of 50,000 or more* Central cities* Places and towns/townships of 10,000 to 50,000* Places and towns/townships of 2,500 to 10,000* Counties*	General housing characteristics	X[1]
Places and towns/town- of 1,000 or 2,500*	Selected housing characteristics	--
HC80-1-B, Detailed Housing Characteristics††		
States SMSA's Urbanized areas Places and towns/townships of 2,500 or more Counties	Summary of detailed housing characteristics	X

1980 CENSUS REPORT (Geographic Areas)	CHARACTERISTICS	ASIAN & PACIFIC ISLANDER
C80-1-B, Detailed Housing Characteristics (con.)++		
United States Regions States	Plumbing, equipment, structural, fuel, and financial characteristics	X[1]
United States Regions SMSA's*** Urbanized areas*** Places and towns/townships of 50,000 or more Central cities*** Places and towns/townships of 10,000 or 50,000*** Counties*	Plumbing, equipment, structural, fuel, and financial characteristics	X
Places and towns/townships of 2,500 to 10,000*	Selected characteristics of housing units	X
HC80-2, Metropolitan Housing Characteristics++		
United States Regions States**** SMSA's**** Central cities**** Places of 50,000 or more****	Detailed cross-tabulations of housing characteristics for occupied housing units by tenure	X

Need for Macro-Level Research

Much of the literature on elderly Pacific/Asians describe the history, problems, and special concerns of this group. Although individual and specific group perspectives assist in an understanding of the present cohort of elders, macro-level research provide the means through which qualitative changes can be made in people's lives. A greater emphasis on approaching the problems confronting minority aged by examining the impact of state and federal legislation, policies, and regulations is long overdue.

Although there are substantial differences in socioeconomic status among Pacific/Asians, many are financially disadvantaged, a status that persists into old age (Asia Science Research Associates, 1976; Owan, 1975). The problem is most severe for women, first generation immigrants, and recently arrived immigrants who tend to have a higher proportion of members in low paying, low status jobs, who are under-employed and under-represented in labor unions and pension plans, and therefore, retire with lower social security and other benefits. Serow (1980) reported that race was the single overriding correlate of poverty status in old age, and that despite the overall decline in poverty among the nation's elders during the last decade, the decline was greater among men than women, among persons in families than unrelated individuals, and among Whites than nonwhites.

Pacific/Asians tend to be underserved in terms of resources and services for the old. Guttmann (1980) reported that Asian elders were overrepresented among those with no knowledge of public benefits, encountered more problems in seeking assistnace than did Blacks or Whites, and differed significantly from other minorities with regard to feelings that prevented them from seeking assistance. For these reasons, among those in need in Guttman's sample, the Asians had the highest percentage of individuals who did not seek aid (43% vs. 26% for Blacks, 33% for Hispanic Americans, and 12% for Whites). This pattern is upheld in a report by Solomon (1978) on a Colorado study that indicated Pacific/Asians were much less likely than either Blacks or Latinos to utilize food stamps despite their eligibility for this income supplement program.

Title VI of the Housing and Urban Development Act of 1970 authorized the federal government to act as insurer to provide crime insurance at affordable prices in states with critical crime insurance availability problems. An examination of the residential policies written between 1973 to 1976 in 17 states and the District of Columbia revealed that approximately 70% of the policyholders were members of the majority culture, despite the fact that the target groups were inner city, predominately minority communities. Although one would expect the incurred loss per claim to be similar across ethnicities, of the groups with claims, the Orientals reported the smallest mean loss: $911.37 vs. $1,111.57 for Spanish Americans, $1,417.14 for Blacks, and $1,514.27 for Whites (U.S. Housing and Urban Development, 1977).

The aged who reside in a dispersed fashion, rather than in high density minority areas are particularly prone to having their needs go unrecognized and unattended. In a survey of community-based services in long-term care, Holmes and his colleagues (1979) found that only 16 of of 62 agencies (27%) in counties with Asian populations served any member of that ethnic group. Most (N = 34, 74%) of the agencies serving no Asians were located in communities where that minority group constituted only one to three percent of the population.

In an examination of public policy measures for the old in the United States, Nelson (1982) depicted a three tiered benefit structure consisting of separate standards for the poor elderly, the lower-middle and middle class elderly, and the high income integrated elderly. Nelson believes the standard for the poor is based on maintaining a subsistence level of support, the standard for lower-middle and middle class elderly is directed at achieving a basic level of "adequacy" and and decency in old age, and the standard for high income elderly is based on maintaining continuity between pre- and post-retirement lifestyles. The vast majority of public benefits are expended for the middle income group of older people, while public expenditures for the highest economic group are significant and growing.

For many Pacific/Asians the socioeconomic status established during their working years determines the benefits received in their later years--levels of support which serves to sustain in old age the inequalities experienced prior to retirement. There are indications that Asian and Pacific Islander older people are under-represented in entitlement programs because of their reluctance to utilize such resources and/or because access to such benefits is difficult. Macro-level research can assist in shedding light on the distribution impact and ascertaining who is actually benefitting from the range of governmental programs for senior citizens. Tax credits for the aged, changes in Social Security benefits, reduction formulae in the tax rates of older workers, alterations in the Medicaid and Medicare programs, and other proposals with long-term economic consequences have been advanced. There is, however, little or no information regarding how any of these measures will affect Pacific/Asians in general, and specific segments of that population in particular.

Need for Multidisciplinary Lifespan Research

Paradoxical though it may seem, an understanding of aging and the aged is sometimes best acquired using a broad lifespan perspective, rather than tightly focusing on old age per se. Many of the conditions and behaviors manifested in late life are a continuation of patterns established early in life. The impact of a life history of lower economic status and employment on the post-retirement period was cited earlier. A similar case can be made for the ethnic differentials in mortality which exist among the various Pacific/Asian groups and between those individuals and their counterparts in the majority population.

Life expectancy at birth has increased through the years for all ethnic groups and the range, or difference, between the longest and shortest life expectancy rates per given year, has narrowed (Gardner, 1980). Life expectancy estimates from Hawaii (Gardner, 1980) and California (Hechter and Borhani, 1965) list the values for Japanese and Chinese as higher than that for Caucasians. Although the longevity of Hawaiians/Part-Hawaiians has improved relative to Caucasians, Japanese, and Chinese since the early 1900s, today the native group still fares poorest with a close to ten-year difference between them and the longest-lived Japanese and a more than four-year difference between them and the Filipinos (whose life expectancy was shorter than the Hawaiians prior to 1930). Not surprisingly, life expectancy at age 65 is also less for Hawaiians/Part-Hawaiians: 12.8 for males and 14.2 for females versus 17.5 and 18.4 for Japanese males and females; 16.5 and 17.7 for the Chinese; 14.2 and 17.4 for the Caucasians; and 14.6 and 16.9 for the Filipinos (Park, Gardner, and Nordyck, 1979).

The Hawaiian/Part-Hawaiian life expectancy approximates the 67 years estimated for the Samoans (Mason, 1981a). The proportion of its members who are 65 years and over (3.5 percent) is less than one-third the national percentage (11 percent), but resembles the statistics of populations in the territories of the Pacific (see Mason, 1980, 1981a, 1981b, and 1981c) Northern Mariana Islands, (2.7 percent); Guam (3 percent); Caroline and Marshall Islands (4 percent); and American Samoa (2.5 percent).

Why do the differentials in life expectancy exist among individuals of various ethnicities? There is little doubt that genetics play an influential role. There is, however, evidence to suggest that environmental and social factors also act as determinants. When compared to persons of Chinese, Filipino, and Japanese ancestries, Hawaiians/Part-Hawaiians are over-represented in deaths which occur early on in life: complications of pregnancy/cogential anomalies/perinatal conditions and symptoms and ill-defined conditions which tend to occur in youth, and homicides and all other external causes, both of which cluster in early childhood (Hawaii State Department of Health, 1980). In addition, Hawaiians/Part-Hawaiians appear especially susceptible to infectious and respiratory conditions--e.g., number per 1,000 persons for asthma is 59.5 vs. 30.2 for Caucasians, 21.1 for Japanese, 31.9 for Filipino, and 36.0 for Chinese; bronchitis/emphysema is 14.6 vs. 16.2 for Caucasians, 6.8 for Japanese, 5.0 for Filipino, and 3.8 for Chinese; respiratory conditions is 133.7 vs. 118.2 for Caucasians, 92.3 for Japanese, 102.8 for Filipino, and 57.0 for Chinese (Hawaii State Department of Health, 1978)--which may increase vulnerability to mortality with the onslaught of the stresses and illnesses associated with aging.

Substance abuse among the aged is an area in which the magnitude and significance of the problem have only recently been appreciated. Estimates of the numbers of elderly alcoholics range from 1 to 2.7 million, and the majority of these problem drinkers are reported to be "unidentified, over-looked, and untreated" (Special Committee on Aging, 1981). As with mortality, there are variations within the Pacific/Asian population and between those ethnic groups and the White population with regard to the use and abuse of alcoholic beverages. Kolonel (1978) and Yuen Schwitters and her colleagues (Yuen Schwitters, Johnson, McClearn, Wilson, in press; Yuen Schwitters, Johnson, Wilson, and McClearn, in press) found Caucasians and Hawaiians/Part-Hawaiians were heavier consumers of alcohol than were the Japanese, Chinese, or Filipinos. The latter investigators also found that despite similarities in reported symptomology, there was a higher proportion of teetolers and individuals who ceased to imbibe once having ingested alcohol among persons of Asian ethnicities than among Whites or Polynesians.

There are many areas of interest to gerontologists and geriatricians which impinge on the well-being and functioning of the aged. In some of these areas--life expectancy and substance abuse were presented as examples--Pacific/Asians can make valuable contributions in our understanding of the basic variables involved and the interactions among these variables. Within the Pacific/Asian population there are groups of people who are particularly vulnerable and others who are particularly resistant to certain conditions. Interestingly, the "resisters" fare even better than members of the majority culture. Why do Caucasians and Hawaiians/Part-Hawaiians with different value orientations resemble one another and differ from Asians with regard to alcohol use and abuse? Why are Hawaiians/Part-Hawaiians, like other native American people--the Indians and Eskimos/Aleuts--at a disadvantage with regard to longevity? What culture practices, lifestyles, or support systems do Chinese, Japanese, and Filipinos employ which "immunizes" them from an early death and substance dependency? These and other questions pertaining to the basic processes of life in old age cannot be adequately answered through even the finest work in a single discipline, nor by limiting the study of the phenomenon exclusively to the later years. Life is a continuous process with an intricate weave of biological, social, and environmental factors. Complex and difficult though they may be, multidisciplinary lifespan approaches in research may offer the least circuitous route to greater insights regarding our understanding of the old.

Need to Examine Common Assumptions

There are many assumptions regarding Pacific/Asians which color perceptions regarding how the elderly members of these ethnicities fare in old age. For example, it has frequently been advanced that:

> Pacific/Asian elders, more often than individuals of other backgrounds, live in extended families.
>
> Pacific/Asians care for elderly parents and grandparents at home, rarely institutionalizing them.
>
> Mental health facilities are under-utilized by Pacific/Asian older people.
>
> Pacific/Asian older people require ethnic specific services and service providers.
>
> Pacific/Asian families are closer and offer more support to older members than do families of other cultural groups.
>
> Elderly Pacific/Asians tend to be conservative in outlook and behavior and acquiescent to authority.
>
> Elderly Pacific/Asians are less independent and assertive and more group oriented than the aged in the majority culture.

Although these and other common assumptions are often subscribed to by many including Asians and Pacific Islanders themselves, there is little factual evidence to substantiate all of the beliefs. There is some data to support the notion that more Pacific/Asian individuals live in multigenerational family households than is true for other minority and majority persons. Using census data, Mindel (1979) demonstrated that in 1975, 3.9% of the males and 13.4% of the females 65 years and over in the United States lived with their children or kin, and that this represented a gradual but inexorable decline since 1940 when the comparable figures were 15.0 and 30.2 percents respectively.

On the other hand, 35% of the Japanese Issei in Osako's (1979) study lived with their children, 100% of the elderly Samoans in Hawaii interviewed by Enesa (1977) shared living quarters with a son, daughter, or with other relatives, and Asian and Pacific Islander aged were reported by Weeks and Cuellar (1981) more likely to be living with children than other elders. In the later investigation, a larger percentage of Filipinos (68%), Samoans (68%), Guamanians (47%), Japanese (43%), Chinese (30%), and Koreans (82%) than nonminorities (9%), Hispanics (12%), Blacks (14%), and American Indians (10%) identified family members as those they would turn to in time of need.

What is not clear are the interactional effects of ethnicity with generation, socioeconomic status, and geographical location with regard to familial supports and living arrangements. In other words, is the observed a singularly ethnic phenomenon, or is it peculiar to the present cohort of elderly Pacific/Asians?

The importance of cultural sensitivity in the delivery of services to aged minorities is a generally accepted premise and upon which is based recommendations for ethnic specific services and contracts to minority organizations (Cuellar and Weeks, 1980; Colen & Soto, 1979). While it may be true that elderly Pacific/Asians are attracted to services with providers of their own ethnic backgrounds and under-utilize services without them, a fundamental research task is to define the basic elements that constitute the reason for program success. What qualities do these ethnic minority staff members possess? Are bilingual ability, good listening skills, knowledge of cultural values and traditions, the ability to empathize, and/or traits essential in the cluster of factors which make up cultural sensitivity? Once these core characteristics have been identified, the following question can be asked: Can the qualities comprising cultural sensitivity be taught to others and can they be evaluated? The importance of these actions lie in their potential to provide tools that can be used to predict, transfer, and evaluate a heretofore nebulous variable. If cultural sensitivity can be predicted, then program directors will be assisted in screening and selecting applicants who have the greatest possibility of performing well with Pacific/Asian older people. If cultural sensitivity can be transferred, then individuals without it or with lesser quantities of it can be taught to relate more competently and effectively with aged Pacific/Asians. And if cultural sensitivity can be evaluated, there will be an objective means available by which staff can be assessed in the performance toward the attainment of program goals.

Research conducted in the explication of cultural sensitivity may make the choice between ethnic specific or ethnic integrated services irrelevant, and suggest it was never the right question. Research data in this area will provide ethnic minority advocates a firmer base to advance their demand that cultural sensitivity be an essential component in all programs for the aged. Insensitivity to culturally different clients no longer need to be tolerated regardless of the numbers these aged represent in the community and the ethnic composition of service providers. This position does force an evaluation of previously held beliefs which were difficult to defend. For example, if the aged and programs must be ethnically matched for optimum services, is there not a form of discrimination operating against Pacific/Asians when their resource options are reduced? Furthermore, why do some ethnically different staff members work better with elders than do staff of the same ethnicity? Disquieting though the examination can be, it creates new and exciting opportunities. For ethnic researchers and service providers, the arena for their expertise in the transfer of knowledge pertaining to cultural sensitivity--in development, training, and evaluation--will be expanded to all aging programs, rather than limited to those that are minority focused. Perhaps the greatest contribution of all will be the freedom of elderly Pacific/Asians to select the services they desire and to be assured that they will be served as adequately as majority group people.

Some of our assumptions regarding Pacific/Asian older people may be truisms, others may contain a kernel of truth, and still others may simply be romanticized ideals relating to the past. All of these common assumptions need to be examined in light of the changing Pacific/Asian patterns in demography, social ascendancy, and assimilation with the majority culture.

In 1970 there were 1.5 million Pacific/Asian individuals in the United States. A decade later their numbers had increased to 3.5 million--a growth rate of 128%, higher than that of the majority or of any other minority group in the nation--and the sharp expansion is expected to continue in the years ahead. The total Asian and Pacific Islander population exceeds the size of the population of 28 states of the Union. Elderly Pacific/Asians are expected to increase at an even faster rate than their younger cohorts, a prediction that is based on the aging of the relatively "young" Pacific/Asian population, their increased life expectancy, and the addition of recent elderly immigrants (sponsored into the United States by children and relatives). The changes wrought by demography and time will result in greater diversity and modifications in the composition of this group. The term Pacific/Asian will be stretched to cover fourth and fifth generation, highly educated individuals who are well assimilated into the majority group, economically secure, and knowledgeable about dealing with the bureaucratic system, as well as recent non-English speaking immigrants with little education and few technical skills, who feel more comfortable living a traditional lifestyle largely within minority enclaves. The preponderance of elderly men in some ethnic groups will disappear, and there will be more elderly women among all Pacific/Asian groups than is true at the present time. The Filipinos and Indo-Chinese will constitute larger proportions of the total Pacific/Asian population, resulting in corresponding reductions in some of the other ethnic groups.

How can Pacific/Asian advocates meet the challenges of an evolving constituency within a rapidly changing society? Although research can probably never provide THE answer, it can be used to assist in providing directions and making more enlightened choices. Research on elderly Pacific/Asians is in its early stages, and like most growing things, if well nurtured it can take a form that will provide many benefits in the future. Careful attention to the areas of inclusionary research, macro-level research, multidisciplinary lifespan research, and the examination of common assumptions pertaining to Pacific/Asian aged will yield especially high returns.

FOOTNOTES

†Report contains 100-percent data; race and Spanish origin data, where presented, are provisional.

††Report contains sample data.

†††Report contains both 100-percent and sample data.

[1] Data are shown separately for the Chinese, Filipino, Japanese, Korean, Asian Indian, Vietnamese, Hawaiian, Samoan, and Guamanian populations.

[2] Data are shown for the nine Asian and Pacific Islander groups (listed in footnote 1) plus the total "Other Asian and Pacific Islander" population.

*Data are shown only for those groups having 400 or more persons in the specific geographic area.

**Data are shown only for those groups having 1,000 or more persons in the specific geographic area.

***Data for American Indian, Eskimo, and Aleut and Asian and Pacific Islander are shown for the specific geographic area having 1,000 or more persons of the population group.

****Data are shown only for those groups having 25,000 or more persons in specific geographic area.

NOTE: Data for towns/townships are shown for 11 States only: 6 New England States (Maine, New Hamshire, Vermont, Massachusetts, Rhode Island, and Connecticut); 3 mid-Atlantic States (New York, New Jersey, and Pennsylvannia); and Michigan and Wisconsin.

φFrom (with modification): Bureau of the Census. 1980 Census Update - Supplement to Data User News, Issue No. 18, April 1981, Pgs. 12-20.

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ANALYSIS OF THE "HUMAN SERVICE MODEL" IN TERMS OF OLDER HISPANICS

Jean Keith Crawford, Ph.D.

The Human Service Model is an attempt by the Subcommittee on Human Services to readjust and reapportion dwindling federal funds for aging programs. Unfortunately for minorities, the Model is formulated to accommodate the average older person in the society. For older Hispanics, the Model falls short of minimal expectations in terms of either need for or equity in the service system. If the options proposed by the Subcommittee are translated into policy, it will mean once again that those in greatest need will receive the least assistance.

The current problem facing policy makers is truly a dilemma. Not only are funds for the aged becoming more scarce, but the aged population is steadily increasing. In short, there are fewer dollars that must be spread among more individuals just when money buys less.

The rapid growth in the aging population comes as no big surpise. We have been forewarned about it by demographers who are reasonably accurate in projecting population specifics, based on past and present trends. It will be around 2015 before the peak of the 1940's baby boom turns 65. According to Uhlenberg (1977), a stationary population may not be reached until about 2050. Until that time, we can expect ever-increasing proportions of aged in the population.

While social scientists and policy makers were prepared to take into account increasing numbers of aged in the population, few were prepared for the cutbacks in funds that are now a reality.

The Human Service Model is composed of seven options. Each option deals with a specific of service provision. Taken together, the seven options answer questions regarding what, for whom, and how services will be provided. The Subcommittee has adopted a platform position on each option. The purpose of this chapter is to:

1. evaluate the Subcommittee's position on each option in terms of appropriateness and equity for older Hispanics;
2. draw on the literature, when available, to shed light on the specific situation of older Hispanics; and
3. comment on factors which must be considered before equity for older Hispanics can be achieved.

I. Discussion of Options

Option One. Who should receive priority for senior services? The Subcommittee proposes that allocation be based on the criterion of age, with those individuals who are 75 years of age and older receiving first priority for services. The selection of this age group over others is based on the logic that those over 75 constitute the aged group in highest need. However, it should be noted that the 75-and-over group is the age group that will grow most rapidly in the future.

Given limited resources, we could reasonably envision future expenditures only for those 75 years of age or older, should this option be translated into policy. How would the imposition of an age criterion of 75 and over affect older Hispanics? In order to answer this question, we must ask yet another question -- namely, what are the chief differences between Hispanic elderly and elderly in the dominant population? Some of the most important differences are:

a) As a group, older Hispanics are more likely to be emotionally disadvantaged. Mean income is lower, and older Hispanics are twice as apt to live below the poverty line as are Anglos (Persons of Spanish Origin in the United States, Bureau of the Census, 1977).

b) Life expectancy is shorter for older Hispanics than for Anglos (Moustafa and Weiss, 1968).

c) Older Hispanics are members of a minority group and as such are subject to multiple disadvantages that accompany minority status (Dowd and Bengston, 1975).

These are only three of the variables on which older Hispanics are more disadvantaged, but the cumulative effect has important implications for the lives of older Hispanics. In addition, researchers must consider the interactional effect of minority status, shorter life expectancy, and lower income.

Older Hispanics would be adversely affected by the "75-and-over" age criterion policy if it were to become reality. Lower socioeconomic status among older Hispanics leads to shorter life expectancy, which means a lower probability of ever reaching age 75. Limiting services to those aged 75 and over eliminates a whole group of older individuals from access to needed resources. This is a clear case of inequity in the distribution of resorces. The inequity can be seen as further discrimination against a group who already suffer multiple disadvantages.

Option Two. Should a future service system for seniors be age-integrated or age-specific? The Subcommittee had adopted the posture that the 60-75 year age group should not be served separately, but that the 75-year-old-and-older group should be served separately. This option shares with Option One the group that is identified for service priorities -- those 75 years and older. However, the logic behind Option Two is somewhat different. Option Two rests on the premises of developmental theory.

The basic argument of nearly every developmental paradigm is that for individuals to remain resonably satisfied over the life course, they must undergo slight modifications in the way they think of themselves or their environment (Hendricks and Hendricks, 1977). Developmental psychologists have assumed that individuals face similar tasks in adjusting to different stages as they pass through life. Following this same line of thought, the Subcommittee proposed that at age 75, individuals become more dependent on outside help. This conclusion is supported by research findings, but it fails to take into consideration one main provision of developmental paradigms -- that of making allowances and adjustments for unusual group characteristics.

The Subcommittee fails to consider the particular life circumstances of older Hispanics. Most would be inadvertently excluded by the adoption of this model due to their low representation in the 75-and-over age group. Option Two would work decidedly to the detriment of all older Hispanics.

Option Three. What kind of services should be involved? Should the model employ a preventive or treatment orientation? The Subcommittee has opted to endorse the preventive approach. The preventive emphasis works best when the population at risk has had access to adequate social services in the past. The plan works less well when the population needs acute care -- especially medical care. Preventive care is meaningless when acute care is warranted. For this reason, a preventive emphasis, without treatment, would not fulfill the needs of older Hispanics. The proportion of service use to service need is very low among older Hispanics. The first national needs assessment of the Hispanic elderly (Lacayo, 1980) indicated that among Mexican-Americans, 73.6 percent reported a need for services that are not currently being received. So long as older Hispanics share unequally in the resources of this country, a model that includes both treatment and prevention must be used to insure minimal services to the "most needy of the needy."

Option Four. Should the emphasis be on acute or long-term care? The weight of the evidence is on the side of long-term care, though there has been little research to evaluate the long-term care model.

The prevailing mode of care in this country has been "acute care." Where nursing home utilization has been studied, it has been noted that Hispanics use nursing homes infrequently. Eribes (1977) noted that Mexican-Americans were dramatically underrepresented in the resident population of nursing homes in Arizona. Eribes also noted that as income goes up, the probability of nursing home institutionalization goes down -- suggesting that such care is reserved as a last resort. On the other hand, there is evidence that living patterns among Hispanics are changing in this postindustrial society. Ragan and Bengston (1977) reported from a community survey that Mexican-Americans prefer to live with their children, but the younger generation does not want to take care of the aged as before. Cuellar and Weeks (1980) reported that 50 percent of older Hispanics in their sample lived alone. Other findings suggest that older Hispanics who live alone use more social services than those who live in other arrangements (Lacayo, 1980). If these findings correctly reflect changes going on in our society, we can expect older Hispanics to utilize nursing homes to a greater extent.

Until now, there have been no studies to determine why older Hispanics use nursing homes less than their proportion in the general society would suggest is appropriate. More research is needed to assess whether personal or demographic factors, or a combination of the two, explain the opposition currently exhibited by older Hispanics. The long-term care model represents the look of the future, but it must be tempered with acute care where needed.

Option Five. What is the scope of services that should be available? Should services be limited or comprehensive? The Subcommittee agrees that services to senior adults (60-75) should be limited, while services to elders (75 and over) should be comprehensive.

For older Hispanics, this approach is unsatisfactory for the same reasons that the positions assumed on Option One and Option Two were unsatisfactory. The objection is based on the disjunction between perceived (or functional) age (which seems to be related to health) and chronological age. Older Mexican-Americans, for example, see themselves as older than their chronological age justifies. For older Hispanics, the position taken by the Subcommittee is unsatisfactory because services to people aged 60-75 are to be limited. Among older Hispanics, age 60 is old -- while age 75 may never be attained.

Option Six. Centralization or Decentralization? The question of centralization or decentralization is especially important for minorities, because when decentralization is the model, minorities are usually short-changed. The hazards of turning over funds and their discretionary use to local authorities are many. In the past, for example, Congress found that revenue-sharing funds administered by local governments did not serve minorities in proportion to minorities' needs. The criteria for distribution of monies by local agencies often work to the disadvantage of minority groups. Block grants on a *per capita* basis are not the way to insure equitable social services when minorities are among the population.

Option Seven. Will the many resources needed for our human service system be found in the public or in the private sector?

The Subcommittee chooses to emphasize the private sector across the board. The "mediating structures" include the family, neighborhoods, voluntary associations, religious groups, and ethnic groups. But Lacayo (1980) reported that fewer than 5 percent of older Hispanics receive sustained financial support on a regular basis from informal networks. Valle and Mendoza (1978) found that 1.8 percent of the older Latinos included in the San Diego study were dependent upon family for assistance. Therefore, it helps very little to reinvest the primary group as "caretakers" when the financial support they give is practically nil. The intent of the Subcommittee's position seems to be that family and community should never have been left out of care for the aged. Family and community should (and do) supply emotional and financial support when possible. But to expect disadvantaged groups to provide care for the aged when the resources at their disposal are very limited is to expect the impossible. We must explore ways to insure that older persons can maintain themselves in the community. Some of the innovative approaches already suggested include incentives and other kinds of rewards to primary group caretakers.

Older Hispanics have never shared equally with other older individuals in the American Dream. Though many have lived for many years in their present neighborhood, and though they have worked hard during that time, they are less likely to receive social security benefits, at age 65, than are their Anglo counterparts. In the needs assessment study, 51 percent of older Mexican-Americans had resided for 20 years or more in their present neighborhood (Lacayo, 1980). On the basis of this information, older Mexican-Americans can hardly be considered a transient population. Even so, only 55 percent participate in social security benefits. This compares with 76 percent of Anglos of the same age (Office of the Los Angeles Mayor, 1975). For Mexican-Americans, years of work may not eventuate in social security benefits.

It is presumptuous for one researcher to propose a model that will equitably serve the older population in this country. In a democracy as diverse as ours, input must necessarily be by many, especially ethnic advocates and researchers. Even so, any model that proports to include equitable services to older Hispanics should take into consideration their many contributions to this country, previous exclusion from the system, their unique life conditions, and their present and past high need for services. As Cuellar and Weeks (1980) have so aptly concluded, equity in the delivery of services to minority elders resides in the utilization of "need" as a criterion for eligibility.

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THE BLACK AGED: REVIEW AND ANALYSIS[1]

Maurice Jackson, Ph.D.

Introduction

This analysis is an application of knowledge of the Black aged to the Human Service Model as developed by the United States House of Representatives Select Committee on Aging (U. S. House of Representatives, 1980). The Model facilitates the bringing together of both issues in the serving of the needs of elderly persons and relevant data. It addresses seven basic issues phrased in terms of choices: (1) priority of service receivers - should persons up to 75 years of age or persons over 75 years of age receive services first? (2) relation to other age groups - should the services be age-integrated or age specific? (3) orientation of services - should they stress a preventive or treatment approach? (4) basic approach of services - should they emphasize acute or long-term care? (5) scope of services - should they be limited or comprehensive? (6) base of services - should they be centralized or decentralized? (7) sources of resources for services - should they be based on public or private sources?

The Select Committee on Aging's response to these choices is that persons over 75 years of age have the first rights to service, that the service must be preventive, decentralized and based upon resources from the private sector. For these elders, services should be comprehensive, long-term, and age-specific. In contrast for seniors below 75 years of age, the services should be limited, acute, and age-integrated.

The Human Service Model is predicated upon several assumptions: (1) The public sector which has been responsible for most of the services to seniors is greatly overextended. (2) Fiscal resources are decreasing. (3) Hence, there is not enough money available today nor will there be enough in the future to meet the needs of seniors. (4) Seniors over 75 years of age are the fastest growing segment in our population. (5) They are also most in need and therefore should have priority in services.

This analysis will relate data on the Black aged to the Model in order to determine the extent to which it is suitable for the Black aged. Ethnic groups are mentioned in the Model only as a part of a natural support system of the private sector. In contrast, the Black aged will be examined as a distinct group with its own situations and circumstances being analyzed in each component of the Model. This approach assumes that distribution of resources is not a new requirement brought about by demographic changes but is necessitated by the cultural value of equality. Some background information about the Black aged will set a framework for understanding the analysis of the Model.

In 1980, there were 2,085,826 Black persons 65 years of age and older in the United States, an increase of more than half a million persons since 1970 (United States Bureau of the Census, 1980; Williams, 1980). Of these individuals in 1980, 1,239,569 (59.4 percent) were women, an increase of over 300,000 persons since 1970.

These population increases which have been steadily occurring since 1910 are reflected among those over 75 years of age. There were

745,852 Black persons over 75 years of age in 1980, an increase of over 200,000 persons since 1970. Of these individuals 465,356 (62.4 percent) were women. Social scientific knowledge of the Black aged has increased also. Studies of this last decade represent the first decade of intensive and extensive study of the Black aged in the history of the country. Comparing a study on the Black aged published a decade ago (Jackson, 1971) the list of references collected by the University Center on Aging, San Diego State University (1981), demonstrates much greater interest in the Black aged in the last ten years. The earlier bibliographic study reported 71 items (published and unpublished) over a period of 20 years, from 1950 to 1971. The bibliographic references from 1970 supplied by the University Center on Aging included 345 items on Black aged (published and unpublished). This means that 83 percent of the works on the Black aged were published in the last decade.

The earlier study concluded that very little was known about elderly Blacks since they were not the object of systematic study. Furthermore, the research focused on social status rather than the aging process. To some extent today, a data base on the Black aged has been compiled although many deficiencies and gaps in the research knowledge still exist. The University Center on Aging's report indicated that the least attention has been given to the subject areas of nutrition, leisure, recreation, transportation, mobility, employment, retirement and education of the Black aged. Yet, knowledge of these areas is very important in understanding their lives. Furthermore, there is a need for studies with more sophisticated designs, more instruments with calculated validity and reliability, more adequately drawn samples, more comparison studies over time, more national studies and more theories in order to resolve some issues in research and to produce much firmer knowledge.

The Human Service Model

For this evaluation of the Human Service Model in terms of the Black aged, we will base our judgment on informed opinion as well as scientific data. Most of the works, with some important exceptions included in this analysis, begin with the year 1975. The latter studies tend to be more sophisticated than the earlier ones and take into account much more information. Also, by this time, some effects of the Supplemental Service Income, established in 1974, might be discernible. Concentration on the most recent literature takes us to the very boundaries of the newest and latest knowledge of the Black aged.

Analysis

The first question of the Human Service Model regarding who has the first right of service is the most important one. The Model specifies 75 years of age as the cutting point between "independent" (those younger than 75) and "dependent" (those older than 75) seniors. Evidence from studies of the Black aged prompt a complex response regarding the use of chronological age as a base for distinguishing among the aged, the lower life expectancy of the Black aged, the "cross-over phenomenon" of those Blacks who live over 75 years of age, and the situation of the Black older women. The decision to use 75 years of age as the criterion for priority of services merely compounds the problem of the use of chronological age (Stanford, 1977; Stanford, 1980). The Model does suggest that a functional age criterion be employed in addition to the chronological one. This does take into account the fact that some persons are physiologically older at an earlier age than others and vice versa and that chronological age is not necessarily the best measure of aging (Morgan, 1968). In short, the Black aged already have been punished by use of an age-criterion of eligibility that is not based upon their life situations. Employment of even an older age of eligibility will only increase the punishment.

As it is now and has been as long as we know, the Black aged have lower life expectancies than their White counterparts (Bell et al., 1976; Daly, 1976; Greene, 1977; Jackson, 1979; Williams, 1980). A Black American male can expect, at birth, to live to age 60 - five years before Social Security eligibility. Black women can expect to live to 68.3 years. White men and women in contrast can expect to live seven to eight years longer (National Institute on Aging, 1980). This means that at the current age of eligibility proportionately more Blacks do not receive Social Security and other benefits (Abbott, 1977; Davis, 1976; Torres-Gil, 1980). They also tend to have lower benefits than the White aged because of the coverage on their jobs when they worked (Abbott, 1977; Hicks, 1977; The National Caucus and Center on Black Aged, Inc., 1981; Thompson, 1979; Thompson, 1975) and proportionately fewer are covered under private pensions (Rosen, 1978; The National Council on the Aging, 1981; Thompson, 1979; Wallace, 1979). The effect, then, of giving service priority to persons above 75 years of age would result in more Black persons not receiving benefits (The National Caucus and Center on Black Aged, Inc., 1981).

Given the general fact that Blacks do not live as long as Whites, there is reason enough to support the use of 75 years of age as an important turning point for the Black aged. It is that once Blacks reach 75 years of age, their life expectancies apparently exceed those of their White counterparts, in what is known as the "cross-over phenomenon" (Ehrlich, 1975; Manton, 1979; National Institute on Aging, 1980). But what is significant in terms of need is the situation of older Black women. They are more numerous than older Black men among this age group. In 1980, 62.4 percent of Black persons over 75 years of age were women. There is general agreement that Black women over 65 years of age, and especially those over 75 years of age, experience quadruple jeopardy, that is to be old, poor, minority and female (Block, 1981; Davis, 1980; Jackson, 1980) and in most respects, are the most needy of the Black aged. This is particularly true for those who live in small town rural areas (Mindel and Wright, 1980). To the extent to which the Black aged are more needy than the White aged, the older Black women might be considered the neediest of the needy and, thus, should receive priority services. Knowledge of the Black aged leads to the conclusion that they should either have the highest priority for service or, at least, be considered as much a prime target as persons over 75. The Human Service Model declares that the aged over 75 are poorer, sicker, less educated, and more likely to be dependent on family, friends, community support, and the government. This is true. Yet a strong case can be made that the Black aged are more needy than the White aged - a matter which raises serious questions about the

Human Service Model as presently constituted and suggests either that it be modified or that another model be developed for the Black aged.

With the understanding that the Black aged are not a homogeneous group - there are important rural-urban and sex differences among others - what has been said about the elderly over 75 years of age can be said about the Black aged in general. The Black aged contrast sharply with the White aged on a number of factors.

(1) Financial - proportionately more Black aged are poorer (Abbott, 1977; Cantor, 1976; Daly, 1976; Jackson and Wood, 1976; National Institute on Aging, 1980; The National Caucus and Center on Black Aged, Inc., 1981; United States Bureau of the Census, 1978; Williams, 1980), say they do not have enough money to live on (The National Council on Aging, 1981; Jackson and Wood, 1976), have less income from insurance (Ralston, 1975), and less savings (Ralston, 1975; Rosen, 1978; The National Council on the Aging, 1981), have to use savings to pay bills (The National Council on the Aging, 1981), are on Supplemental Security Income and public assistance (Abbott, 1977; Blau, 1979; The National Council on the Aging, 1981).

(2) Health - proportionately more Black aged are sicker (Cain, 1980; Davis, 1975; Jackson and Wood, 1976; National Institute on Aging, 1980; Primm, 1978; Rosen, 1978; Williams, 1980), perceive health as less favorable (Cantor, 1976), have higher rates of hypertension (Jackson, 1978; Manton, et al., 1979; National Institute on Aging, 1981; Oliver, 1975; Roberts, 1977), see poor health as a very

serious problem (The National Council on Aging, 1981), have a higher incidence of most chronic diseases (Weaver, 1977), receive medical care less often (Davis, 1975; Jackson and Wood, 1976; Solomon, 1978), have less coverage under Medicare services (Davis, 1975; The National Council on the Aging, 1981), are disabled and disability occurs at an earlier age (Torres-Gil, 1980), are in State Mental Hospitals (Kart and Beckman, 1976), have difficulty obtaining needed health services (National Institute on Aging, 1980; Federal Council on the Aging, 1978), are more unable to afford medical care in general (Cuellar and Weeks, 1980), and Medicare specifically (Hill, 1978), tend to age younger (Morgan, 1968), proportionately fewer are in nursing homes (Hicks, 1977; Ingram, 1977; The National Caucus and Center on Black Aged, Inc., 1981), and their life expectancy is lower (Bell, et al., 1976; Daly, 1976; Greene, 1977; Jackson, 1979; Williams, 1980; National Institute on Aging, 1980).

(3) Social - proportionately more Black aged are more likely to be dependent on the family (Cantor, 1976; Jackson and Wood, 1976; Williams, 1980), tend to be suspicious of bureaucratic processes (National Institute on Aging, 1980), feel government should assume more responsibility for the elderly (The National Council on the Aging, 1981), have higher probability of spouse death (Solomon, 1978; Williams, 1980).

(4) Housing - proportionately more Black aged have poorer housing (Johnson, 1978; National Institute on Aging, 1980;

Rosen, 1978; Solomon, 1978), have less paid off mortgages (The National Council on the Aging, 1981), are more likely to be renters (The National Council on the Aging, 1981).

(5) Service - proportionately more Black aged have difficulty obtaining services (National Institute on Aging, 1980; Federal Council on the Aging, 1978), and have a higher level of need for services (Blau, 1979).

(6) Employment - proportionately more Black aged have higher unemployment rates (Federal Council on the Aging, 1980), reported not enough job opportunities (The National Council on the Aging, 1981), are less prepared for retirement (The National Council on the Aging, 1981), were in lower occupational categories when they worked (Jackson and Wood, 1976).

(7) Crime - proportionately more Black aged have more fear of crime, have higher homicide rates, and are more often victims of crimes (Ragan, 1976).

(8) Education - proportionately more Black aged are less educated (Bell, et al., 1976; Hudson, 1976; National Institute on Aging, 1980; Federal Council on the Aging, 1980; The National Council on the Aging, 1981; United States Bureau of the Census, 1978).

If services should be granted first to those most in need, the Black aged would rank first since their needs are so much greater (Cuellar and Weeks, 1980). Not only do the inequities enumerated above handicap the Black elderly, but their life-long systematic character intensifies their effect (Whittington, 1975). Most of these needs have been an integral part of their lives, since they have fewer opportunities than Whites of meeting them satisfactorily.

This is not to assert that the overall needs of the Black aged are unique but to recognize that many consistent and enduring problems are more prevalent among them. The most common explanations for the continuance of the situation of the Black aged as just described are racial prejudice (National Institute on Aging, 1980), racial discrimination (Davis, 1975; Kasschau, 1977; Peterson, 1977), racism (Hudson, 1976; Jackson, et al., 1977; Oliver, 1975), double jeopardy of age and race discrimination (Dowd and Bengtson, 1978; National Institute on Aging, 1980; Jackson and Wood, 1975; National Urban League, 1964), and even multiple hazards (Lindsay, 1971).

Not only are the Black elderly more needy than White elderly, but their population is increasing at a faster rate than both the general population and the White elderly (Williams, 1980). This means that unless great efforts are undertaken now, there will be a larger population of persons with severe unmet needs, whose needs cannot be adequately met by services aimed first at the aged over 75.

Although it is quite clear that the need for service is very great for the Black aged, it may be very difficult if not impossible to give them first priority for services. At the very least, we suggest that any service model that becomes law should give great attention to the Black aged so that their situation will not become exacerbated beyond what it is.

In lieu of priority service, it is apparent that the Black aged need affirmative action or similar direct plans and programs to relieve their circumstances. Without such efforts the equality in care that is the hallmark of a democracy will not be achieved.

With regard to relationship to other groups, the Human Service Model suggests that service to those over 75 years old be age-specific and those under 75 years old age-integrated. This matter has not been one of serious research with regard to the Black elderly's situation. A study (Cantor, 1979) does conclude that Black aged women who were integrated with the younger generation were better off than women living alone. It would appear, on the one hand, that to the extent it is true that the Black aged are in close contact with other age groups (Hill, 1972) that age-integrated services would be appropriate. On the other hand, health problems of the Black aged such as hypertension are so severe that only age-specific services will begin to ameliorate them. One other matter needs to be considered here and in the discussion of other components of the Human Service Model. It is the existence of change, its direction and speed. Hurling (1978) claims that the number of Black aged living with their offsprings is on the decline; therefore, it would appear that age-specific services will become more appropriate at some later date.

Preventive rather than treatment services are seen as more desirable in the Human Service Model. Although this issue has been a research focus for a number of investigators (Cain, 1980; Cantor, 1976; Eve, 1979; Faulkner, et al., 1975; Guttman, 1980; Laurie, 1980; Rao, 1980; Scott and Kivett, 1980; Wright, 1979), there is yet no firm agreement as to which approach is more suitable for the Black aged. Guttman (1980) reports that the high degree of unawareness of services by the Black aged makes prevention difficult if not impossible.

Conversely, increase in awareness of service would lead to a greater possibility of preventive services. Cantor (1976) claims that little money for adequate care makes treatment, let alone prevention, difficult to achieve. A low degree of understanding of services by the Black aged led Laurie (1980) to claim that prevention is difficult for them to achieve. On the other hand, Wright (1979) argues that prevention is possible to the extent outreach and follow-up clinics are developed; while Cain (1980) claims that the more critical health problems of aged Blacks require preventive service.

In general, prevention is a useful ideal; it can reduce the need for treatment. However, treatment may be more appropriate for populations in trouble. Once the problems are treated and brought under control, it will be easier to institute preventive services. Perhaps some populations need both services. Finally, a change from treatment to preventive services may require changes in health-seeking practices as well as programmatic additions in the delivery of health services.

The Human Service Model proposes a change from care in reaction to acute needs to that which emphasizes long-term needs. Services for acute care can be included. The multiple long-enduring problems of the Black aged seem to require long-term services. More severe impairment at lower ages (Laurie, 1980), less availability of home care (Engler, 1980), chronic conditions (Williams, 1980), less access to nursing homes (Jackson, 1978), lower education (Tallmer. 1977) and similar problems of the Black aged make long-term services necessary. The extent to which these difficulties stem from racism (Dancy, 1977;

Henry, 1978) discrimination (Engler, 1980), and cultural barriers to services (Kivett and Learner, 1980) makes long-term care imperative.

According to the Human Service Model, the scope of services should be limited for seniors under 75 years of age and comprehensive for elders over 75 years old. The former need only assessment, referral, and advocacy; the latter, outreach, evaluation, and case management. For aged Blacks, the opinion seems to be that their wide range of needs requires comprehensive services. Barriers to health care (housing, income, etc.) are seen as needing comprehensive care and attention (Bell, et al., 1976; Gordon, 1979), as do poor and chronic health problems (Williams, 1980); low awareness of existing services (Gordon, 1979; Primm, 1977); triple jeopardy (Daly, 1976); and cultural barriers to services (Kivett and Learner, 1980).

The next component of the Human Service Model addresses the issue of centralization versus decentralization. A decentralized approach is suggested by the Model in which the federal government provides money directly to the states. In turn, the local Area Agencies on Aging, primarily responsible for elders over 75 years of age, would also be responsible for assessment, referral, and advocacy for those seniors under 75 years of age. This is an oversimplified version of the Human Service Model's resolution of the issue of centralization-decentralization, but it is sufficient for our purposes.

The last component of the Model involves the use of public or private source of resources for services to the elderly. The Human Service Model would utilize private sources. Since these last two components parallel each other, I will respond to both together before discussing them separately.

In assessing the success or failure of the federal government and the public sector in serving the elderly it is not enough to emphasize the role of the states and the private sector as a meaningful alternative. Both the state governments and the private sector have been less involved than the federal government and the public sector in giving services to the Black elderly. In fact, the development of services by the federal government has kept the situations of the elderly from deteriorating by providing a measure of care and assistance. A more useful approach might be to use the strength of both federal (Johnson, 1978) and state governments and of both public and private sectors. At the least, any criticism of the role of the federal government and public sector needs to be complemented by a critical assessment of the roles of the states and private sectors in service to the elderly.

The Human Service Model ends by stressing the need for empowering private natural support systems such as the family, neighborhoods, voluntary associations, religious groups, and ethnic groups. I have already commented on the inadequacy of the Model's treatment of Blacks as a support group, which is the only instance in which minority groups are discussed.

Much more research needs to be conducted on these natural systems. The evidence on the supportive aspects of the family of the Black aged are contradictory. Dancy (1977) argues that older Blacks rely greatly on the supportive services of their families. Hurling (n.d.) finds intergenerational conflict in a Black community. Seelbach (1980) reports no difference between Black and White aged in the filial responsibility of their adult offsprings toward them. Bell, et al., (1976) sums this up as a set of contradictions in the strengths of families for the Black aged. Clearly, more research is needed in this area.

One study, Clemente (1975), finds voluntary associations to be more important to the Black aged than the White aged. Older Blacks belonged to more associations and had higher attendance rates. Clemente attributes this to the higher proportion of church associations older Blacks belonged to.

Religion has been viewed as very important among the Black aged (Dancy, 1977). Jackson and Wood (1976) also find religion to be considered more important by the Black aged.

To facilitate evaluation of the private/public segment of the Human Service Model, it is necessary to research the influence of neighborhoods and racial identity on the Black aged. It will also be useful to examine the services older Blacks perform for other groups in their community and in the nation.

Summary

This summary briefly treats the major points that were made relative to the various components of the Human Service Model. First, giving priority to the 75 years and over age group for services will compound the problems that the Black aged already have. Since their life expectancy is shorter, it would reduce further the number of Black aged who are currently receiving benefits. Functional age criteria would be more suitable to the Black aged as would a lower age level of eligibility than is currently being used. The great differences between Black and White aged indicate that the Black aged are more needy and therefore they should rank among the top with respect to receiving services. Affirmative action and similar programs are strongly needed for the Black aged, especially if the Human Service Model becomes law. This is especially true for Black women over 75 years of age.

Second, to the extent it is true that the Black aged are in close contact with other age groups it would appear age-integrated services would be more appropriate. However, target age-specific services may reduce the plight of the Black aged more since the services would be expressly directed at them. Also due to the seemingly decrease of Blacks living with offsprings, it would be more appropriate to focus on age-specific services.

Third, both treatment and preventive services would serve the Black aged better. The high degree of unawareness of services by the Black aged may make prevention impossible, although prevention is the ideal approach. No firm agreement has been established on this issue. This indicates a great need for future research in this area.

Fourth, long-term care is imperative for the Black aged. The multiple long-enduring problems of the Black aged require long-term services.

Fifth, comprehensive services are needed for aged Blacks. Barriers to health care, housing, income and so on show a need for comprehensive care.

Sixth, centralized approach or some combination of the strengths of both the federal government and the state governments appears to be more suitable to the life situations of the Black aged.

Seventh, it is difficult at this time to determine the extent to which private natural systems are more supportive for the Black aged than the White aged and the degree to which the public or private sector renders more service. The magnitude of the situation of older Blacks may well call for a more intensive effort on the part of both public or private sectors.

So, the Human Service Model proposed that persons over 75 years of age be granted the first rights to service which must be preventive, decentralized and based upon private resources. Service can be limited or comprehensive, acute or long-term, or age-integrated or specific depending upon whether persons are older or younger than 75.

The Human Service Model applied to the Black aged has to be greatly modified. It would not make age distinctions except for Black women over 75 years of age. Service needs to be long-term and comprehensive and either age-integrated or specific, preventive or treatment oriented, centralized or decentralized, and public or private or some combination.

These models, to the extent to which these distinctions are valid, differ enough so that it will be necessary to make a special effort to meet the needs of the Black aged if the Human Service Model becomes law.

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CROSS-CULTURAL SUMMARY AND CONCLUSIONS

Whether aging in America is a success story remains a debatable point, particularly with respect to minorities. Certainly because of the significant gains in health care provided some sectors of society, life expectancy has increased dramatically among the majority of Americans. Health and life expectancy rates among minority populations remain significantly lower than for the dominant majority. Nonetheless, because the post-war baby boom will eventually become a senior and elder boom, the proportions of older persons in all segments of society are sure to reach significantly higher levels by the year 2000. This is particularly true of minority segments in society.

How this demographic transformation is defined determines how aging-in-society issues are addressed and operationalized in public policy and programs for the aging. If, as in the case of the proposed Human Service Model: (1) the concept, "frail elderly," is operationally defined as the attainment of a predetermined age (75+), under the explicit assumption that, "those below age 75 are more independent than those 75+"; (2) "some forms of functional dependence are manifest in most persons at about 75+"; and (3) then set up an arbitrary system that mandates segregated aging services and programs for those 75+; the results will be precisely what Alex Comfort has conceived of as "sociogenic aging."

By ignoring, (1) that functional dependence rather than chronological age is the best indicator of need in later life; (2) the available research findings that suggest non-White minority older persons are more dependent, and at an earlier chronological age, than older persons in the White majority; and (3) that some forms of dependence are found most in older minorities 55+; the "Human Service Model" compounds matters and problems for minority aging. The Human Service Model is a prime example of policy by stereotyping, segregation, paternalism, and ignorance.

As minority older persons increase in number and their unmet needs escalate because no preventive measures have been taken, a human service crisis can be predicted: society cannot afford to first conceive and then ignore minority aging as a "non-problem," victimizing those in greatest need by not targeting older minorities for services. A societal tragedy is thus created and compounded by public policy.

As a result of the comprehensive ethnic-specific analyses of the Human Service Model by Drs. Red Horse, Moriwaki, Schwitters, Crawford and Jackson, our understanding of the proposed changes leads to the following general conclusion: raising the chronological age of eligibility for program participation; targeting a full floor of age-segregated services only for those 75+; employing a preventive with little treatment orientation; providing only assessment, active referral, advocacy and other limited services to senior adults; making those 75+ the major service responsibility of the local Area Agency on Aging (AAA); consolidating adult service monies at the federal level and distributing them to states in block grants on a per-capita basis, with a weighted factor for senior adults (60-75); distributing elder services monies (for the full floor of comprehensive care) to states through the Older Americans Act, the categorical grant for care to elders, with states distributing them according to state plan, in conjunction with local AAAs; making the Administration on Aging only a consultant to Congress on policy and to the aging network for technical assistance; and emphasizing the private sector rather than public sector resources; all can cause neglect of, and serious harm to, older minority persons.

It is clear that minority aging is a complex, heterogeneous experience. A conceptual distinction is now made between "White ethnics" and "ethnic (non-White) minorities." A conceptual distinction is also made according to general ethnic group classification (Alaskan Native/ American Indian, Black, Hispanic, Pacific/Asian) and specific ethnic heritage (Mexican American, Puerto Rican, Hawaiian, Samoan American, Navajo and Apache, for example).

Another conceptual distinction now being made is between minority "natives" (United States-born), "pioneers" (young adult and middle-age immigrants to the United States), and "followers of children" (later life immigrants to the United States). "Followers of children" appear to be poorer, sicker, less educated, and more likely to be dependent on family, friends, community, private and public agencies for support. Projections suggest that the latter group is among the fastest growing segments of the minority aging population.

After extensive review and evaluation of the proposed Human Service Model, it clearly addresses some important aging issues for the most dependent and needy older persons. A revised human service strategy for older persons is needed. The overhauled system should include delineation of the most important issues involved in human services to minority older persons, squarely addressing the problems raised by each, and examining potentials and limitations of various solutions, in terms of both present and future trends. As the present state-of-the-art of minority aging is reviewed, the series of aging human service options, some research and policy recommendations have been made for each option. Recommendations for a coherent, research-based, future-oriented policy on aging that is primarily concerned with those most functionally dependent and in greatest need are necessary.

Who Should Receive Aging Services?

Policy should provide that those truly in need - the functionally dependent - have first rights to benefits and services, and should be the focus of future aging policy and program development. What appears most equitable for minority older persons is an aging policy based on functional dependence eligibility criteria, rather than chronological age. Primary research emphasis should be given to the development of an equitable cross-cultural measure and definition of "functional dependence" as a multi-dimensional phenomena.

Should Future Aging Services be Age-Integrated or Age-Specific?

In order to adequately address this issue, more data is needed on comparable ethnic-specific morbidity and mortality rates, as well as the number and types of chronic conditions among older minorities and their severity and limitations, not only by generational cohort, but also by immigration wave and geographic location. Present findings suggest that some minority older persons report being more comfortable with services provided in an aging context, while others prefer services in an age-integrated context. An important point is that the latter rarely appears as a deterrent. The extent to which minority older persons are integrated into the family and community systems, as opposed to living alone and away, may determine whether age-integrated family or adult services are more appropriate than age-specific or segregated services.

What Types of Services Should be Involved? Should the Aging Service Model Employ a Preventive or Treatment Orientation?

As long as minorities continue to have unequal access to health services at earlier stages of life, the aging services model must include both treatment and prevention to insure survival of the most dependent and needy older persons. More research attention must be given to obtaining comparable ethnic-specific longitudinal data on factors related to well-being, and identifying those which can be used to maintain and promote health and well-being in later life among older minorities of different cultural traditions.

Should the Emphasis be Acute or Long-Term Care?

Research findings suggest that for minority older persons, the most responsive aging services system includes both acute and long-term care in a comprehensive program. More information is needed about the needs of functionally dependent older persons in different ethnic minority communities for comprehensive, long-term care, and about the needs of their support networks, particularly immediate family members. More research is also needed on the complex combination of factors that explain the findings that minority older persons use long-term care facilities less than statistical expectations suggest.

Should the Scope of Services be Limited or Comprehensive?

Any senior adult or elder who is functionally dependent should have comprehensive care, a full floor of services, with outreach, evaluation, and case management by the aging network. Research is needed on how minority older persons may be affected by some of the proposed changes in public programs that affect older persons' needs (for example, changes in Social Security benefits, reduction formula in the tax rates of older workers, alterations in the Medicaid and Medicare programs, tax credits for the aged, and tax credits for care of the elderly). An important research question is: How can referral and advocacy more effectively serve the needs of older minorities who are not receiving the benefits of minimum care and have probably never experienced all the needed services for which they qualify?

Should Policy Making and Service Provision in Aging be Centralized or Decentralized?

Although ideologically, a decentralized system seems most feasible and more responsive to the needs of older persons in minorities communities, the efficacy of block grants versus direct funding of ethnic-specific projects has yet to be assessed. The decentralization of aging resources endorsed by minority aging specialists differs from the proposed Human Service Model in that it calls for direct funding of monies from federal government to minority service organizations and agencies. This facilitates the development of natural systems such as the families, neighbors, and ethnic community members to provide for the needs of the needy older minorities. More research is needed on whether a centralized or some combination of a centralized/decentralized approach appears most suitable for development of programs that best meet the needs of functionally dependent older minorities.

Will the Many Resources Needed for an Aging Human Services System be Found in the Public or the Private Sector?

Much more research is needed on the nature of natural systems for minority older persons; current findings are contradictory and fragmented. To better understand the role of private segments of minority communities, it is necessary to research the influence of neighborhoods and ethnic community identification on the conditions of older minority persons. More data is also needed on the extent to which minority community social structures are actually used by minority older persons to alleviate their problems and on the extent to which the natural support systems in fact exist for older minority persons of different ethnic heritages.

More data are needed to indicate whether programs developed by ethnic-based community agencies have been more successful than others at reaching and serving the needs of functionally dependent older minorities. The efficacy of the "Hawaiian" service delivery system to older persons of different cultural heritages through requisition of waivers that allow the maintenance of cultural traditions and extended-family networks needs to be demonstrated and examined elsewhere. Specific "set-aside" funds may be necessary to assure that the most needy benefit from "first rights."

THE MINORITY AGING BIBLIOGRAPHIES

To compile the most extensive reference collection on minority aging required a multi-faceted approach. Resources and methodologies utilized in the development of the Minority Aging Codification Project bibliographies are described in this section. This background information is important to the understanding of the scope of the project. A guide to utilization of the following bibliographies is also provided.

Reference information for the Minority Aging Codification Project was obtained from a wide range of sources. All staff of the University Center on Aging contributed documents and the project received numerous articles, reprints, monographs, and meeting presentations from professionals and government agencies all across the United States. These were sent in response to individual letters of request and the call for documents published in several 1981 issues of MINORITY AGING EXCHANGE, as well as other national newsletters. All four collaborating organizations contributed reference information and documents, as well as valuable leads to "fugitive" or difficult-to-obtain materials. The project authors also provided assistance in data acquisition. Project research assistants reviewed numerous gerontology, social science, and minority aging journals for literature, with particular attention to publications dated from 1970 to the present. In addition, computerized literature searches were made and analyzed for new materials.

The review of other bibliographies on minority aging and related topics was a most valuable resource for the project. Whenever possible, referenced documents were obtained and, if appropriate, entered in the project collection. If it was not possible to acquire and analyze documents, due to staff time constraints or availability, the reference was entered in the Uncodified Bibliography (see page 288).

A List of Bibliographies (see page 190) contains all bibliographies reviewed by project staff and utilized in the preparation of the project collection. A list of Unreviewed Bibliographies (see page 193) provides more bibliographies identified by staff as related to minority aging, but which were not individually reviewed during the project. The project bibliographies and collection; however, may contain many of the references in these unreviewed bibliographies due to the redundancy of referenced materials among bibliographies.

Upon acquisition of documents, the general guidelines for inclusion and exclusion of materials were applied. Examples of materials appropriate for inclusion in the collection include: (1) research publications; (2) research project preliminary and final reports; (3) literature reviews; (4) published or formal service program or model project reports; (5) assessments of public policies; (6) curriculum guidelines and training materials; (7) unpublished meeting presentations; and (8) dissertations and master's theses. Examples of materials for exclusion include: (1) letters, editorials, memos, and book reviews; (2) pamphlets, catalogs, and brochures; (3) annual reports of institutions, agencies, and organizations; (4) questionnaires or survey instruments; and (5) computer search output.

The five bibliographies developed from the project (American Indian/ Alaskan Native, Pacific/Asian, Hispanic, Black, and Multi-Ethnic) represent the entire collection and contain only analyzed documents. All documents acquired were analyzed for minority and aging focus.

Articles must significantly address both areas to have been included. Each reference is subject and ethnicity coded as follows: ethnic group(s)/subject. The key to the codes is shown on page195.

Although it was frequently a difficult decision, each article was assigned only one major subject code. Articles that reviewed or addressed numerous topics with equal attention were coded as Literature Review/Overview (LO). The twelve subject categories were broad classifications for wide topic scope. The key to subject coding is shown on page 195.

Ethnic group codes were combined under four major categories and only articles that were coded exclusively within these categories were included in the four corresponding ethnic-specific bibliographies. Any article that was coded in more than one major category was included in the Multi-Ethnic Bibliography. Articles coded as Minority Groups (MG) were automatically entered in the Multi-Ethnic Bibliography. Ethnic group codes were combined as follows: (1) American Indian/Alaskan Native (American Indians, Navajo Americans, Alaskan Natives);(2) Hispanic (Hispanic Americans, Mexican Americans, Puerto Rican Americans, Cuban Americans);(3) Black (Blacks); and(4) Pacific Asian (Pacific/Asian Americans, Asian Americans, Japanese Americans, Chinese Americans, Pilipino Americans, Samoan Americans, Korean Americans, Guamanian Americans, Hawaiian Americans).

The six state-of-the-art bibliographies which follow constitute a comprehensive collection of 1,600 references. These bibliographies have a wide application for anyone who is interested in the status of the field, by subject area and ethnic focus. Although many of the materials can be located at major libraries across the nation, the majority are now in the archive collection at the University Center on Aging, San Diego State University.

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Ethnic Group

AI = American Indians
NA = Navajo Americans
AN = Alaskan Natives
BL = Blacks
HI = Hispanic Americans
MA = Mexican Americans
PR = Puerto Rican Americans
CU = Cuban Americans
PA = Pacific/Asian Americans
AA = Asian Americans
JA = Japanese Americans
CA = Chinese Americans
PI = Pilipino Americans
SA = Samoan Americans
KA = Korean Americans
GA = Guamanian Americans
HW = Hawaiian Americans
MG = Minority Groups

Subject

HE = Health
NU = Nutrition
SF = Social Network/Family Relations
PL = Public Policy/Legislation/Legal
HL = Housing/Living Arrangements
ER = Employment/Retirement
IE = Income/Economics
TM = Transportation/Mobility
MH = Mental Health
ED = Education
LR = Leisure/Recreation
LO = Literature Review/Overview

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AMERICAN INDIAN/ALASKAN NATIVE

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